

EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
CIVIL ACTION NO. 1:23-cv-00480-CCE-LPA

PLANNED PARENTHOOD SOUTH)
ATLANTIC, ET AL.,)
)
Plaintiffs,)
)
vs.)
)
JOSHUA STEIN, ET AL.,)
)
Defendants,)
)
-and-)
)
PHILIP E. BERGER, ET AL.,)
)
Intervenor-)
Defendants.)

VIDEOTAPE DEPOSITION OF

MONIQUE WUBBENHORST, M.D., M.P.H.

1:16 P.M.

WEDNESDAY, AUGUST 30, 2023

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WUBBENHORST

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P R O C E E D I N G S

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THE VIDEOGRAPHER: We're now on the record. The time is 1:16, August 30th, 2023. This is the video deposition of Dr. Monique Wubbenhorst. Case name is Planned Parenthood South Atlantic, et al., v. Joshua Stein, et al.

Counsel, if you would please introduce yourselves.

MR. MENDIAS: This is Ryan Mendias with ACLU on behalf of Dr. Beverly Gray, one of the plaintiffs in this case.

MS. AMIRI: Brigitte Amiri also with ACLU representing Dr. Gray.

MS. GRAUNKE: Kristi Graunke, ACLU North Carolina, representing all plaintiffs.

MR. BENJAMIN WOOD: Benjamin Wood, law student intern at the ACLU of North Carolina.

MR. BOYLE: Ellis Boyle, Wake County Bar, representing the legislative leader defendants, Senator Berger and Speaker Moore. Kevin, you're up.

MR. MOORE: South --

MR. WILLIAMS: This is Kevin Williams

1 and -- on the Zoom and I am representing
2 defendant District Attorney Jim O'Neill.

3 MS. PAYNE: Julia Payne --

4 MS. O'BRIEN: Good after- --

5 MS. PAYNE: -- with Alliance --

6 MS. O'BRIEN: Good afternoon. I'm --
7 if I could just go after Kevin. Good
8 afternoon. I am Elizabeth O'Brien. I'm
9 representing the remaining district attorneys
10 in the lawsuit.

11 MS. PAYNE: Julia Payne with Alliance
12 Defending Freedom representing the
13 legislators.

14 MR. MICHAEL WOOD: This is Michael
15 Wood. I am counsel to Secretary Kinsley from
16 DHHS.

17 MR. BULLERI: This is Michael Bulleri.
18 I am counsel for the North Carolina Medical
19 Board and the North Carolina Board of
20 Nursing.

21 MS. SALVADOR: This is Anjali Salva- --

22 MR. MOORE: This is South --

23 MS. SALVADOR: Oh, go ahead.

24 MR. MOORE: Sorry. This is South
25 Moore, North Carolina Department of Justice,

1 representing Attorney General Stein.

2 MS. SALVADOR: This is Anjali Salvador
3 with Planned Parenthood Federation of America
4 representing Planned Parenthood South
5 Atlantic. Also on the Zoom from Planned
6 Parenthood Federation of America are Kara
7 Grandin, Peter Im, and then the 11W-13 is a
8 conference room with our paralegals, Vanisha
9 Kudumuri and Shealyn Massey.

10 THE REPORTER: Is that everyone?

11 * * *

12 MONIQUE WUBBENHORST, M.D., M.P.H.,
13 having been first sworn or affirmed by the court
14 reporter and Notary Public to tell the truth, the
15 whole truth, and nothing but the truth, testified
16 as follows:

17 EXAMINATION

18 BY MR. MENDIAS:

19 Q. Good afternoon, Doctor.

20 A. Good afternoon.

21 Q. My name is Ryan Mendias and, like I said, I'm
22 an attorney with the ACLU. I represent
23 Dr. Beverly Gray, one of the plaintiffs in
24 this case. So just some initial housekeeping
25 questions.

1 You understand that you're under oath
2 and that you have a legal obligation to
3 answer everything truthfully and completely?

4 A. Yes.

5 Q. I'll ask that you wait until I finish my
6 question before you start answering and that
7 way we can avoid talking over one another.

8 A. Yes.

9 Q. And if you don't understand a question,
10 please let me know. I can rephrase or repeat
11 it and I'll do so.

12 If you do answer a question without
13 asking for clarification, I will assume that
14 you've understood it, okay?

15 A. Yes.

16 Q. And so please answer all questions verbally
17 as you've been doing instead of shaking your
18 head or saying uh-uh or uh-huh.

19 And so during this deposition your
20 attorney may object, but his objections are
21 just for the record. So after he makes them,
22 you should proceed to answer the question.

23 A. Yes.

24 Q. And if at any point you realize that an
25 answer that you previously gave wasn't

1 complete or wasn't fully correct, you should
2 feel free to stop me and we can go back and
3 discuss the answer again.

4 Does that sound all right?

5 A. Thank you. Yes.

6 Q. Okay. And if you don't do so, we can assume
7 that you stand by the accuracy and
8 completeness of your questions?

9 A. Yes.

10 Q. Great. And if you need a break, please let
11 me know. We can definitely do that but -- as
12 long as there's not a question pending. If
13 there is a question pending, you'll need to
14 answer the question and then we can proceed
15 to the break.

16 A. Yes.

17 Q. Okay. Is there anything today that would
18 prevent you from giving a full and accurate
19 testimony, medications, illness, anything
20 like that?

21 A. No.

22 Q. Okay. Is this the first time you've given a
23 deposition?

24 A. No.

25 Q. When have you given depositions before?

- 1 A. I gave a deposition in 2017 for a Texas case.
- 2 Q. Is that the only deposition that you've
- 3 given?
- 4 A. Yes.
- 5 Q. Okay.
- 6 A. No. I've given one deposition when I was a
- 7 resident that -- no, I wasn't a resident. It
- 8 was -- I graduated from residency. It was
- 9 around 1995 or 1996.
- 10 Q. What was the subject of that deposition?
- 11 A. It was an infant that had delivered in the
- 12 hospital when -- while I was a resident.
- 13 Q. Was it a malpractice case? What -- what sort
- 14 of case was it?
- 15 A. Yeah, I think it was a malpractice case. I
- 16 wasn't very educated about legal questions at
- 17 that time.
- 18 Q. Were you a defendant in that case?
- 19 A. The hospital that I did my residency at,
- 20 which was Yale New Haven Hospital, was the
- 21 def- -- defendant.
- 22 Q. Have you ever participated -- oh, I'm sorry.
- 23 Did you have more to add to that?
- 24 A. I -- I'm not a lawyer so I'm just making sure
- 25 I say the right thing.

1 Q. Sure. Sure. Have you ever participated in a
2 lawsuit as a defendant?

3 A. No.

4 Q. Have you ever participated in a lawsuit as a
5 plaintiff?

6 A. No.

7 Q. Have you participated in a lawsuit in any
8 other capacity?

9 A. No.

10 Q. Well, I assume you've participated as an
11 expert witness in --

12 A. Oh, as an expert witness --

13 Q. Yes.

14 A. -- but not where it was me --

15 Q. Not as --

16 A. -- personally.

17 Q. -- a party?

18 A. Right.

19 Q. Okay. And when have you participated as an
20 expert witness in previous lawsuits?

21 A. You mean -- not speaking to giving a
22 deposition, just being involved? Okay.

23 Q. Correct.

24 A. So let's see. Kentucky -- for the state of
25 Kentucky, for the state of Minne- --

1 Minnesota. The cases were in the state of
2 Kentucky, state of Minnesota, state of
3 Kansas. And I feel like I'm forgetting one.
4 Kentucky, Minnesota, Kansas. Oh, and Texas,
5 as I said, uh-huh.

6 Q. And in your role as an expert, have you
7 testified in court?

8 A. Yes.

9 Q. In which of those cases did you testify in
10 court?

11 A. Texas.

12 Q. Any others?

13 A. No.

14 Q. And have you testified before any legislative
15 body?

16 A. Yes.

17 Q. Could you say more about that testimony that
18 you gave.

19 A. Yes. The Senate Judiciary Committee in --
20 2007, 2008, or 2009 was their -- I'm sorry.
21 I --

22 Q. That's all right.

23 A. -- don't know. And then the House of
24 Representatives last fall and the Senate in
25 April.

1 Q. And what was the nature of the testimony that
2 you gave before those legislative bodies?

3 A. I was testifying on the -- abortion safety
4 and maternal mortality.

5 Q. And is it fair to say that the expert
6 opinions that you offered in those cases that
7 we just discussed were in support of laws
8 restricting or regulating abortion?

9 A. I don't -- no, I don't think so because I
10 think that in the Senate case, as I
11 understood it, it was a -- regarding
12 legislation that was being proposed that
13 would remove abortion restrictions, as I
14 understood it.

15 Q. Right. So I think my question is more
16 specifically about the cases in which you've
17 been an expert witness so Kentucky, Texas --

18 A. Oh. Oh. Oh. Yes.

19 Q. -- Minnesota.

20 A. Right.

21 Q. And in those cases, you were offering an
22 opinion in support of abortion restrictions;
23 is that correct?

24 A. Yes.

25 Q. And the piece of legislation in the Senate

1 that you mentioned, is that the Women's
2 Health Protection Act?

3 A. That's correct.

4 Q. And were you in favor or opposition of
5 that --

6 A. I was --

7 Q. -- act?

8 A. -- in opposition. I'm sorry. Didn't mean
9 to --

10 Q. Oh, no, no.

11 A. -- speak too early.

12 Q. Totally fine. Thank you. So you're aware
13 that the Speaker of the North Carolina House
14 of Representatives and the President of the
15 North Carolina Senate have intervened in this
16 litigation to defend the constitutionality of
17 several laws relating to abortion; is that --

18 A. Yes.

19 Q. Okay. So if I say the intervenors, can we
20 agree that I'm referring to those
21 individuals, the Speaker and the Senate
22 President?

23 MR. BOYLE: Object to form.

24 A. I'm sorry. I don't understand what you mean.

25 Q. So I might refer to the intervenors, who your

1 attorney here is counsel for --

2 A. Uh-huh.

3 Q. -- as the intervenors. When I say the
4 intervenors, I mean the President of the
5 North Carolina Senate --

6 A. Uh-huh.

7 Q. -- and the Speaker of the House of North
8 Carolina's House of Representatives.

9 A. Yes.

10 MR. BOYLE: Object to form. You can
11 answer.

12 BY MR. MENDIAS:

13 Q. So when were you first contacted by counsel
14 for intervenors about participating in this
15 case?

16 A. I would have to look at my scheduler.

17 Q. Was it months ago, weeks ago?

18 A. Let's see. This is now August. It was no
19 more than two months ago, but, again, I -- I
20 can't -- you can't hold me to that because I
21 would have to look at my scheduler. I -- I
22 don't want to not respond truthfully.

23 Q. I understand. Thank you. Who have you been
24 communicating with regarding this -- your
25 participation in this case?

1 A. Julia Payne, who's counsel for ADF, and
2 Attorney Ellis.

3 Q. And are you being paid for your participation
4 in this case?

5 A. Yes.

6 Q. How much are you being paid?

7 A. \$700 an hour.

8 Q. And roughly how many hours have you spent
9 preparing for this case so far?

10 A. More than 30.

11 Q. And did you bring anything with you to this
12 deposition?

13 A. Yes.

14 Q. What did you bring?

15 A. I brought my declaration, which is here.
16 Would you like to see it?

17 Q. No. It's all right.

18 A. Okay. And then I brought ACOG Practice
19 Bulletin 193, a study by Alisa Goldberg, a
20 study by Ushma Upadhyay, and a study by Karen
21 Borchert.

22 Q. Okay. And I have my own copy, but I think
23 the answer will be yes.

24 MR. MENDIAS: But I will just ask that
25 this be marked as Exhibit B.

1 (WUBBENHORST EXHIBIT B, Declaration of
2 Monique Chireau Wubbenhorst, M.D., M.P.H.,
3 was marked for identification.)

4 BY MR. MENDIAS:

5 Q. But can you confirm that this is an accurate
6 copy of the declaration that you submitted in
7 this case.

8 A. It looks as though it is, yes.

9 MR. MENDIAS: Oh, and then I have a
10 copy for you, Ellis, as well.

11 MR. BOYLE: Thanks.

12 BY MR. MENDIAS:

13 Q. Can you please describe the process of
14 drafting this declaration.

15 A. The process. In other words, how I arrived
16 at my opinion? Is that what you mean?

17 Q. I mean more specifically how you went about
18 writing the -- this particular document.

19 A. So I had at hand the declarations from
20 Dr. Alsle- -- Dr. Boraas, actually, I'm
21 sorry, and Dr. Farris. I reviewed those, I
22 reviewed the studies that they cited, and
23 then I did a literature search on the topics
24 that they discussed, used the snowball
25 technique to add additional studies and used

1 the -- distilled those into my declaration
2 and my opinion.

3 Q. And what keywords did you use in doing that
4 search?

5 A. I looked at abortion complications. I looked
6 at terms abortion plus complications,
7 abortion-related mortality, ectopic
8 pregnancy, pregnancy of unknown location.
9 And there -- I'm sure there were others, but
10 those -- those were the major -- some of the
11 main ones.

12 Q. Did anyone provide any particular studies
13 they wanted you to cite in this expert
14 declaration?

15 A. No.

16 Q. Did anyone ask that you include a particular
17 fact or opinion in this declaration?

18 A. No.

19 Q. And I'd like to talk about your CV, which I
20 will ask to be marked, please.

21 (WUBBENHORST EXHIBIT C, Curriculum
22 Vitae, was marked for identification.)

23 MR. MENDIAS: Thank you.

24 BY MR. MENDIAS:

25 Q. Is this an -- look like a -- oh, sorry.

1 MR. BOYLE: Thank you.

2 BY MR. MENDIAS:

3 Q. Does this look like an accurate copy of the
4 CV that was attached to your expert
5 declaration?

6 A. Yes.

7 Q. Okay. And I note that the date is May 25th,
8 2023.

9 A. Uh-huh.

10 Q. Is this the most recent version of your CV?

11 A. No, there's a more recent version.

12 Q. What would have changed between that version
13 that you submitted and -- and the most recent
14 version?

15 A. I think I discovered an error in my previous
16 CV. There was a hospital that I worked at in
17 North Carolina that I hadn't listed on my CV.
18 It's -- I believe it was Moses Cone Hospital.
19 I'm actually in the process of updating it
20 now.

21 Q. And when did you work at Moses Cone Hospital?

22 A. 2004, 2005. I was there once as a locum
23 tenens.

24 Q. And I note on your CV as well that you're a
25 fellow of the American College of

1 Obstetricians and Gynecologists, which I'll
2 refer to as ACOG; is that accurate?

3 A. Yes.

4 Q. And what is ACOG?

5 A. It is a professional organization that
6 many -- I think most OB/GYNs but not all
7 belong to in the United States.

8 Q. And you've presented papers at ACOG
9 conferences; is that correct?

10 A. That's correct.

11 Q. Do you believe that ACOG is a reliable source
12 of information for OB/GYNs?

13 A. Not always.

14 Q. On which topics is it not reliable?

15 A. I think that in terms of their abortion
16 advocacy, they do not always reflect the --
17 the, I would say, preferences and practices
18 of their constituency.

19 Q. Are there any other topics besides abortion
20 that you find ACOG to be unreliable on?

21 A. I haven't reviewed all of their literature so
22 I couldn't answer that.

23 Q. But of the literature that you've reviewed,
24 you find it all reliable except for abortion;
25 is that correct?

1 A. I think that there are some areas that I
2 couldn't bring to mind at this exact moment
3 where I would say that they have not cited
4 all of the available literature.

5 Q. Is there -- can you give any inkling as to
6 what those areas might be?

7 A. I would have to go back because I haven't
8 looked at those areas recently.

9 Q. I understand. To be a member of ACOG, does
10 a -- an OB/GYN need to express any particular
11 view of abortion?

12 A. No.

13 Q. So ACOG then has members who are opposed to
14 abortion?

15 A. Actually, the vast majority do not perform
16 abortions.

17 Q. My question was whether they have members who
18 are opposed to abortion.

19 A. Yes, they do.

20 Q. Great. You also indicate on your CV that
21 you're a member of the American Association
22 of Pro-Life Obstetricians and Gynecologists,
23 which --

24 A. Yes.

25 Q. -- I'll refer to as AAPLOG; is that correct?

1 A. Yes.

2 Q. And you actually served on their board. Is
3 that right, too?

4 A. Yes.

5 Q. How long was your time as a board member?

6 A. I want to say about three years.

7 Q. And was it continuous or did you have various
8 stints as a board member?

9 A. No. It was continuous.

10 Q. And what did your duties as a board member of
11 AAPLOG include?

12 A. They were most -- similar to any board. We
13 oversaw the activities of the organization,
14 coordinated with the CEO, reviewed scientific
15 papers that AAPLOG put out, among others.
16 AAPLOG is A-A-P-L-O-G. Yeah.

17 Q. Thank you for that. Could a physician become
18 a member of AAPLOG if they did not oppose
19 abortion?

20 A. I don't know.

21 Q. What if I -- I'm going to introduce another
22 exhibit. This, I believe, is Exhibit --
23 so...

24 MR. MENDIAS: Thank you.

25 (WUBBENHORST EXHIBIT D, AAPLOG Mission

1 & Vision Statement, was marked for
2 identification.)

3 BY MR. MENDIAS:

4 Q. Does this look like the mission and vision
5 statement of AAPLOG?

6 A. It does.

7 Q. Okay.

8 A. But I can't confirm that because I haven't
9 looked at it in a while.

10 Q. Okay. Do you remember what the mission and
11 vision of AAPLOG was when you were on the
12 board?

13 A. I think similar to what's here. And, again,
14 not being able to quote it because it's been
15 some time, it was to defend the lives of the
16 pregnant mother and her unborn child.

17 Q. And that necessarily means prohibiting
18 abortion in most circumstances, correct?

19 A. Yes.

20 Q. Okay. And I actually have another exhibit.

21 (WUBBENHORST EXHIBIT E, AAPLOG
22 Practicing Physician of any Specialty Form,
23 was marked for identification.)

24 BY MR. MENDIAS:

25 Q. And, Dr. Wubbenhorst, do you recognize this

1 document, if not necessarily its particular
2 form, what it is with respect to AAPLOG?

3 A. Yeah. I haven't -- I -- it's been a while
4 since I've seen this so I don't know if this
5 is the current one or not.

6 Q. But when you say one, what -- one of what?
7 What do you mean?

8 A. Well, this looks like the form that you would
9 use to join --

10 Q. Okay.

11 A. -- but it's been -- I've been a member for
12 some time so I can't speak to this.

13 Q. But you would have filled something similar
14 out when you became a member, correct?

15 A. Yes.

16 Q. And physicians joining the organization while
17 you were on the board would have filled out a
18 similar form --

19 A. Uh-huh.

20 Q. -- correct?

21 A. Yes. Sorry.

22 Q. And could you read the first sentence under
23 the heading, Practicing Physician of any
24 Specialty?

25 A. Practicing Physician of any Specialty --

1 Physicians of any Specialty are those
2 Physicians (either M.D. or D.O.) who agree
3 with our mission statement and su- -- support
4 AAPLOG with annual dues and donations.

5 Q. And as we just discussed, AAPLOG's mission
6 statement includes prohibiting abortion; is
7 that right?

8 A. I don't think it's prohibiting abortion. I
9 think it's restricting abortion or advocating
10 for the life of the mother and the unborn
11 child.

12 Q. Okay. So restricting.

13 You were also on the board of Americans
14 United for Life, which I'll refer to as AUL;
15 is that correct?

16 A. That's correct.

17 Q. You're currently on the board?

18 A. Yes.

19 Q. And what are your duties on that board?

20 A. So it is to oversee the -- the board oversees
21 the activities of the organizations -- of the
22 organization and also works with the CEO in
23 accomplishing its mission.

24 Q. And what is the mission of AUL?

25 A. It is to serve as the architects of the

1 pro-life movement or --

2 Q. And -- I'm sorry. Did you have more to say
3 that --

4 A. No.

5 Q. Apologies if I cut you off at all. When you
6 say, architects of the pro-life movement,
7 what does that specifically mean?

8 A. Well, I think I'm not articulating very
9 clearly, you know, what the mission is.
10 That's kind of what I would call the general
11 way that they -- general -- how they're seen
12 and how they see themselves. I would have to
13 review the curr- -- the mission statement to
14 give you a precise answer. I don't want to
15 give you an imprecise answer.

16 Q. So speaking generally, what is it that the
17 organization hopes to accomplish in this
18 country?

19 A. It supports legislation supporting the life
20 of the wo- -- woman and her unborn child.

21 Q. And is it true that AUL advocates for what
22 they call abortion abolition?

23 A. I don't know.

24 Q. Does AUL believe that abortion should be a
25 matter of state law as opposed to something

1 regulated at the federal level?

2 A. I think that they consider both pathways --
3 I'm sorry. I saw your cup that said,
4 Pathways, and that's what came into my mind.
5 I think they consider both strategies.

6 Q. And whether it's a pathway or a strategy,
7 what is the ultimate goal of AUL?

8 A. I think it's to promote life.

9 Q. Not to ban abortion nationwide?

10 A. I would say that if you were to ask members
11 of the board and people working in the
12 organization that, similar to AAPLOG, it is
13 to advocate for the life of the unborn child
14 and for the mother.

15 Q. Okay. I'm -- I'm going to play a video
16 briefly and I'll ask the court reporter how
17 best to --

18 MR. MENDIAS: Do you mind if we go off
19 the record to discuss how we do this? We
20 can...

21 THE VIDEOGRAPHER: Going off the
22 record. The time is 1:37.

23 (Discussion off the record.)

24 THE VIDEOGRAPHER: Back on the record.
25 The time is 1:37.

1 MR. MENDIAS: All right. And I will
2 mark this as the next exhibit.

3 (WUBBENHORST EXHIBIT F, AUL Video Clip,
4 was marked for identification.)

5 (Video played and stopped.)

6 BY MR. MENDIAS:

7 Q. Dr. Wubbenhorst, do you believe that that
8 fairly represents the mission of AUL?

9 MR. BOYLE: Objection. Are you saying
10 that's an AUL document?

11 MR. MENDIAS: It -- I am, yes.

12 MR. BOYLE: Can you establish that
13 first, please. Sorry. Not to --

14 BY MR. MENDIAS:

15 Q. Does this -- or do you recognize this video
16 at all?

17 A. Yeah. I have seen it, yes.

18 Q. And it is from AUL?

19 A. Uh-huh.

20 Q. Correct?

21 A. I'm sorry. Yes.

22 Q. Thanks. So do you believe that this
23 accurately encapsulates the mission of AUL?

24 A. Yes.

25 Q. Do you agree with this mission?

1 A. Yes.

2 Q. And so I take that to mean that you
3 personally oppose abortion in all
4 circumstances?

5 A. Yes.

6 Q. In fact, you believe that abortion is a moral
7 and social evil, correct?

8 A. Yes.

9 Q. Is it fair to say that you believe abortion
10 is murder?

11 A. I think it's a nuanced question. I think
12 that if you are saying -- and, again, I'm not
13 a lawyer, but are you referring to the mother
14 who has the abortion or are you referring to
15 the abortionist who performs the abortion?

16 Q. Let's deal with them one by one. Do you
17 think a woman who seeks and obtains an
18 abortion has committed murder?

19 A. No.

20 Q. Do you think a physician who performs an
21 abortion has committed murder?

22 A. Yes.

23 Q. Do you believe that what you might call
24 elective abortions should be illegal in all
25 circumstances?

1 A. Yes.

2 Q. Does that include cases where the pregnancy
3 is the result of rape or incest?

4 A. Yes.

5 Q. And that would include cases no matter the
6 age of the rape victim?

7 A. I'm sorry.

8 Q. Would you oppose abortion in a case where
9 pregnancy is the result of rape or incest
10 when the rape victim is a child?

11 A. Yes, because I have taken care of minors who
12 were the victims of incest who chose to carry
13 their children to term and said that this --
14 they -- in particular, they've told me two
15 things. They said that, without this baby, I
16 would not have evidence that he did it, and,
17 I also feel that this child is redeeming this
18 circumstance -- this terrible circumstance
19 that has happened to me.

20 Q. Do you believe that all child victims of rape
21 feel the same way about carrying their
22 rapist's baby to term?

23 A. I can't speak for how all child victims feel.

24 Q. Do you think it's possible that some would
25 not feel that way?

1 A. I think it's possible.

2 Q. And do you think that delivering a child is
3 the only way to establish the paternity of a
4 rapist?

5 A. I'm not understanding your question. Without
6 DNA, how would you establish paternity?

7 Q. Do you believe that DNA can only be obtained
8 from a child that has been delivered?

9 A. I think that there are techniques now for
10 confirming paternity, but at the time that I
11 was speaking of with these children, that
12 technology was not available.

13 Q. Do you think that when an abortion is
14 performed, a -- that there is a way to
15 determine forensically who the rapist was
16 based on the products of conception?

17 A. That's not what I'm -- what I was saying. I
18 was telling you what a patient had actually
19 told me.

20 Q. Okay. But you would agree that after an
21 abortion, the products of conception can be
22 used to identify the rapist?

23 A. Yes.

24 Q. And do you believe that all abortions, even
25 those that have no medical complications,

1 cause harm to women?

2 A. Yes. That's based on my clinical experience
3 of caring for thousands of woman. I've never
4 met a woman who was happy that she had an
5 abortion. Relieved? Yes. Feeling as though
6 she couldn't do anything else? Yes. But all
7 women to one degree or another were damaged
8 by that experience, some very damaged, some
9 not so much.

10 Q. When you say women were relieved, what about
11 their relief made you think that they were
12 damaged?

13 A. Because they all expressed sorrow at having
14 undergone the abortion and many of my
15 patients report that every year when that
16 child would have been born, they have a
17 ceremony to mourn their death.

18 Q. What percentage of patients would you say
19 have disclosed to you that they had an
20 abortion?

21 MR. BOYLE: Object to form.

22 BY MR. MENDIAS:

23 Q. You can answer.

24 A. I'm not understanding the question. You mean
25 if I asked -- you -- you're talking about

1 patients that I ask?

2 Q. How did you come to know that those patients
3 had had abortions?

4 A. I routinely ask them.

5 Q. And in answering that question, do you then
6 ask how they felt about their abortion
7 experience?

8 A. I do.

9 Q. All of them?

10 A. Yes.

11 Q. Are you currently practicing medicine?

12 A. Yes.

13 Q. Where?

14 A. Indiana.

15 Q. Where specifically in Indiana are you
16 practicing medicine?

17 A. Saint Joseph's Regional Medical Center.

18 Q. And what do you do there?

19 A. I'm a hospitalist there.

20 Q. And what does that mean?

21 A. I cover the labor floor in shifts and any
22 women that come in through the emergency room
23 or come into triage or who are laboring, I
24 provide backup for the other clinicians or we
25 have our own practice where we care for those

1 patients in labor as well. And I also
2 practice internationally.

3 Q. You don't perform abortions, do you?

4 A. No.

5 Q. And you've never performed an abortion?

6 A. No.

7 Q. Have you ever observed a physician performing
8 an abortion?

9 A. Yes.

10 Q. How many?

11 A. One.

12 Q. In residency were you offered the opportunity
13 to learn how to perform an abortion?

14 A. Yes.

15 Q. And you declined that opportunity?

16 A. Yes.

17 Q. What -- have you ever induced labor in a
18 pregnant patient before the fetus was viable?

19 A. Yes.

20 Q. In what circumstance would you have to do
21 that?

22 A. Would I or have I?

23 Q. Have you?

24 A. Where a woman had infection and needed to be
25 delivered because she had clear signs of

1 chorioamnionitis.

2 Q. And do you remember how far along in her
3 pregnancy this patient was?

4 A. She was between 21 and 23 weeks.

5 Q. You don't consider induction in that
6 circumstance to be an abortion?

7 A. No, because of the principle of double
8 effect.

9 Q. Could you say more about what that is.

10 A. It means that when your intention is to save
11 the life of the mother, the outcome of fetal
12 death may be an unavoidable and tragic
13 consequence, but that is not the intent,
14 whereas, in abortion, the intent is clearly
15 the death of the unborn child.

16 Q. Where -- do you think that some physicians
17 would call induction in that circumstance an
18 abortion?

19 A. I can't say.

20 Q. How do you --

21 A. I think they would. I think there are some
22 people that would say that.

23 Q. Have you ever performed a dilation and
24 curettage procedure on a patient?

25 A. Yes.

1 Q. In what circumstances have you performed a --
2 a dilation and curettage?

3 A. Can you be more specific? Are you referring
4 to a living fetus or a dead fetus?

5 Q. I'm talking about any time that you've
6 performed that particular procedure.

7 A. Yes.

8 Q. So in what circumstances have you performed a
9 D&C, either for a living or dead fetus?

10 A. Hemorrhage, a woman who was infected with a
11 demised fetus in the second trimester. And
12 I -- if you can clarify, you're referring
13 strictly to D&C in pregnancy, not D&C in a
14 nonpregnant woman?

15 Q. Correct.

16 A. Okay.

17 Q. Thank you for that clarification. So have
18 you ever performed a D&C when there is
19 embryonic or fetal cardiac activity?

20 A. No.

21 Q. Do you believe that physicians who perform
22 abortions are degraded by the pos- --
23 procedure?

24 A. I do. And I have a great deal of sympathy
25 for them. I feel that many people -- it's --

1 it's very interesting. When you look at
2 statistics, people graduate from residency
3 and a high percentage stopped -- planning to
4 do abortions and a high percentage stopped
5 doing abortions within five years. And I
6 think others really feel very -- speaking to
7 physicians who were abortionists who then
8 decided to leave -- stop becoming
9 abortionists, they've described to me how
10 they felt terrible going to work every day,
11 they felt morally conflicted, so I have a
12 great deal of sympathy for them.

13 Q. About how many physicians who previously
14 provided abortions but no longer do have you
15 spoken to?

16 A. Five.

17 Q. Five. When you provide medical care in the
18 hospital, you've -- do you encounter patients
19 who were referred to your care from the
20 emergency room?

21 A. Are you -- you're talking about obstetrical
22 patients?

23 Q. Correct.

24 A. Yes.

25 Q. And throughout your career, how many do you

1 think you have encountered who are
2 transferred from the ER to your service?

3 A. So you're referring to my current practice in
4 the first -- let me -- when you asked me the
5 question the first time, you said right now.
6 Are -- were you referring to my current
7 practice?

8 Q. I'm not sure if I said right now and if I
9 did, I misspoke. I meant throughout the
10 entirety of your medical career.

11 A. Have I -- just to make sure I understand, so
12 have I cared for patients who were referred
13 through the emergency room?

14 Q. Correct.

15 A. Yes.

16 Q. And my question is, about how many over
17 your --

18 A. Thousands.

19 Q. Thousands. Is it more than 10,000?

20 A. No, less than 10,000. Somewhere between
21 probably 5- and 10,000.

22 Q. And about how many of those patients were in
23 North Carolina?

24 A. I would have to think because I practiced in
25 nine hospitals in North Carolina but a total

1 of close to 30 hospitals elsewhere. So it --
2 I -- I would have to think about that.

3 Q. If I give you a few seconds or a minute, do
4 you think you could come up with a ballpark?

5 A. It would be quite a few. It would be quite a
6 few, yeah.

7 Q. Would you say closer to a hundred or a
8 thousand?

9 A. It would be more than a hundred, probably
10 considerably more than a hundred --

11 Q. So --

12 A. -- because I was a solo practitioner at many
13 of these hospitals when the covering OB/GYN
14 went out of town.

15 Q. And so would it be closer to 500 or a
16 thousand?

17 A. It's somewhere in that range, yeah.

18 Q. Okay. And so out of all the patients -- now
19 I'm talking in any hospital in any state that
20 you've described as --

21 A. Or country.

22 Q. -- in -- or country. I -- I would like to
23 limit in -- to the United States so any
24 state.

25 A. The pathologies are the same, though.

1 Q. Sure. I'm specifically wondering about
2 patients transferred from emergency rooms to
3 your obstetrical service.

4 A. Right.

5 Q. Does that -- does that alter the number of
6 patients --

7 A. No, because I've practiced --

8 Q. -- you --

9 A. -- more here than --

10 MR. BOYLE: Object to form. You can
11 answer.

12 BY MR. MENDIAS:

13 Q. Sure. So I believe you said it was thousands
14 of patients throughout your career.

15 A. Yeah. I've been in practice more than 30
16 years.

17 Q. Okay. And of -- out of those thousands of
18 patients, how many have you encountered who
19 were experiencing complications from an
20 induced abortion?

21 A. None from an induced abortion. From
22 procedural abortion, yes.

23 Q. Okay. From an abortion of any kind?

24 A. Yes.

25 Q. How many?

1 A. Two.

2 Q. Two.

3 A. No. More than two. Yeah, more than two.

4 Let me just think for a minute.

5 Q. Sure.

6 A. I'd say ten or less.

7 Q. Ten. Dr. Wubbenhorst, do you recall earlier
8 you said that you were -- you participated in
9 a deposition in Texas?

10 A. Yes.

11 Q. Is that correct? Okay.

12 MR. MENDIAS: So I'm going to mark the
13 transcript of that deposition as an exhibit.

14 (WUBBENHORST EXHIBIT G, Deposition
15 Transcript of Monique Chireau, M.D., October
16 14, 2017, was marked for identification.)

17 BY MR. MENDIAS:

18 Q. So, Dr. Wubbenhorst, you'll see that the
19 numbers are on the top right of each page and
20 that there are four pages per printed page.
21 So direct you to Page 138. So it would be in
22 the top right. Are you there?

23 A. Yes.

24 Q. Okay. So beginning with Line Number 9,
25 there's a question. Have you ever managed a

1 patient who is experiencing a complication
2 from an induced abortion?

3 A. Yes.

4 Q. Your answer was, Yes?

5 A. Uh-huh.

6 Q. And then the question was, How many times?

7 A. Right.

8 Q. And then you answered, Probably four times.

9 A. Yes.

10 Q. So are you suggesting now that it was
11 actually ten times or have --

12 A. No. I've seen --

13 Q. -- there been --

14 A. -- more patients --

15 MR. BOYLE: Objection.

16 A. -- with --

17 MR. BOYLE: You can answer.

18 A. Yeah. I'm not suggesting that this was
19 incorrect. I'm saying that I've seen more
20 patients since then.

21 Q. Okay. Where have you seen those patients?

22 A. Internationally.

23 Q. Internationally. In the United States, have
24 you seen any patients --

25 A. No.

1 Q. -- suffering from -- okay. And have you seen
2 any patients experiencing complications from
3 an abortion of any type in North Carolina?

4 A. No.

5 Q. So just because I know that your CV might be
6 a little out of date, I wanted to ask, are
7 you currently a senior research associate at
8 the Center for Ethics and Culture at the
9 University of Notre Dame?

10 A. Yes. Well, my job title has changed. I
11 think I'm a senior fellow.

12 Q. Okay. What does that position entail?

13 A. I use -- I'm still do- -- I'm doing research
14 and so I have an office at Notre Dame and I
15 have access to -- I work with people in the
16 center on different projects and I use Notre
17 Dame's considerable resources to carry out my
18 research.

19 Q. What sort of research do you do?

20 A. Women's health epidemiology, demography,
21 maternal mortality.

22 Q. Do you -- would you say that abortion is a
23 focus of your research?

24 A. No. It's one focus.

25 Q. So I -- I asked if you would say abortion is

1 a focus of your research and I just want to
2 be clear. What is your answer?

3 A. I'm just clarifying that it's one focus.

4 Q. Okay. So you consider it to be a focus of
5 your research?

6 A. Yes.

7 Q. Have you ever served as a peer reviewer for a
8 publication?

9 A. Multiple publications, yes. I think that's
10 in my CV as well. You've seen that.

11 Q. Yeah. What do you understand the purpose of
12 peer review to be?

13 A. In peer review what we attempt to do is to
14 evaluate papers for their research methods,
15 their applicability to the general literature
16 and so on, and decide whether they should be
17 published.

18 Q. Have you ever published a peer-reviewed
19 article or paper on the topic of abortion?

20 A. No.

21 Q. Are you familiar with the complication rate
22 for abortion in North Carolina?

23 A. Yes.

24 Q. And what is it?

25 A. I would have to look at my deposition, but I

1 believe that the -- the overall complication
2 rate is listed by CDC. I would have to look
3 at the -- the exact data to be sure.

4 Q. So are you familiar with the abortion
5 reporting requirements in North Carolina?

6 A. Yes.

7 Q. What are they?

8 A. They state that abortionists need to report
9 the com- -- their complications and -- to the
10 North Carolina Department of Public Health as
11 I understand it.

12 Q. And are you familiar with the
13 pregnancy-associated death rate in North
14 Carolina?

15 A. Yes.

16 Q. And can you say what that is?

17 A. I would have to just confirm it. I don't
18 want to give you a wrong number.

19 Q. When you say confirm it, do you mean in your
20 declaration or --

21 A. I believe I brought that up in my
22 declaration, but, again, the maternal
23 mortality rate is -- it depends on -- when
24 you say, pregnancy-associated death rate, I
25 think those are two different numbers. The

1 pregnancy-associated death rate would include
2 deaths in the first trimester, for example,
3 from ectopic pregnancy. It would also
4 include deaths from abortion and it would
5 include maternal deaths toward the end of
6 gestation as well and those are three very
7 different numbers.

8 By far, the number that we have the best
9 data for, in my opinion, is maternal
10 mortality. We have -- our data on -- on
11 deaths due to ectopic pregnancy and abortion
12 is very limited.

13 Q. So during your testimony before the court in
14 Kentucky last year -- do you remember
15 testifying in --

16 A. Yes.

17 Q. -- Kentucky? -- you described treating
18 preeclamptic women.

19 A. Yes.

20 Q. And you testified that if a woman was getting
21 sicker, you would deliver her. Sometimes
22 depending on the capacity of the place you
23 were when you were delivering her, you might
24 have to call helicopters or planes or
25 ambulances to transport the woman and her

1 infant to a better-equipped hospital.

2 Does that sound correct?

3 A. Yes.

4 Q. And I think your specific testimony was that
5 you had done so plenty of times. Does that
6 sound right?

7 A. Yes.

8 Q. About how many times, if you had to estimate,
9 have you had to transfer -- we can just pick
10 one of those forms of transportation --
11 transfer a woman via ambulance to a place
12 where she could get care that could not be
13 provided where you had delivered her?

14 MR. BOYLE: Object to form. You can
15 answer.

16 A. I would say for ambulance transfers, most of
17 the places where -- most of the facilities
18 where I worked where I had to transfer
19 patients, time was of the essence so
20 relatively few ambulance transfers and more
21 helicopter or plane transfers.

22 Q. If you had to give a ballpark, could you?

23 A. For both?

24 Q. Yes, please.

25 A. I would say somewhere between 20 -- somewhere

1 around 20 --

2 Q. For ambulance?

3 A. -- patients.

4 Q. Oh, that includes both?

5 A. Yes.

6 Q. And could you be more specific within that 20
7 how many were in ambulances, how many were in
8 helicopters?

9 A. Helicopters or planes, probably ten to a
10 dozen and then maybe ten to -- probably not
11 as many as -- I would have to think about it
12 a little bit more.

13 Q. Okay. So --

14 A. Again, mostly, those were in places like
15 South Dakota or remote parts of Arizona.

16 Q. And you'd say -- so eight to ten is maybe a
17 fair ballpark for how many --

18 A. For?

19 Q. For ambulance transfers.

20 A. I would have to really think about it, yeah.

21 Q. All right. So in your declaration you cite
22 five examples of patients transferred from
23 Planned Parenthood South Atlantic, which I'll
24 call PPSAT, that -- their Chapel Hill clinic
25 to UNC Hospital between February 2022 and May

1 of 2023; is that --

2 A. Yes.

3 Q. Yes? Okay. Do you have firsthand knowledge
4 of these patients?

5 A. The patients who were transferred?

6 Q. Yes.

7 A. No.

8 Q. How did you learn of these hospital -- or
9 these ambulance transfers?

10 A. I don't remember exactly how I came across
11 them. I think that when I was looking at the
12 question of hospital transfers, transfers
13 from facilities to hospitals, this
14 information popped up and then I started to
15 dig a little bit deeper into it and found the
16 9-1-1 transcripts.

17 Q. I notice in your declaration you cite for one
18 of these ambulance transfers a website called
19 operationrescue.org.

20 A. Yes.

21 Q. Did they all come from Operation Rescue?

22 A. No.

23 Q. And Operation Rescue is an antiabortion
24 organization, correct?

25 A. Yes. I don't know very much about them.

1 Q. Okay. Are you aware that the man who
2 murdered Dr. George Tiller, an abortion
3 provider in Kansas, in 2009 asserted that he
4 was affiliated with Operation Rescue?

5 A. I can't speak to that.

6 Q. Are you aware of any other ambulance
7 transfers from any of PPSAT's clinics during
8 the period of February 2022 to May 2023?

9 A. I'm not.

10 Q. Do you know how many abortions PPSAT provided
11 between February 2022 to May 2023?

12 A. No.

13 Q. If you were to go about calculating the rate
14 of hospital transfers per abortion patient,
15 how would you do that?

16 A. Hospital transfers from PPSAT Chapel Hill?

17 Q. Correct.

18 A. I think that what I would look at is how many
19 abortions were performed and how many
20 ambulance transfers actually occurred.

21 Q. So in your declaration you also say that it's
22 an axiom in medicine that physicians should
23 not perform procedures if they are not able
24 to manage their complications.

25 Do you agree with that statement?

1 A. That's correct for most procedures.

2 Q. Which procedures does it not apply to?

3 A. I think that a good example is screening
4 colonoscopy because with screening
5 colonoscopy, if a patient undergoes a
6 perforation, that's usually a -- a
7 complication that would be managed
8 surgically.

9 Q. So you don't believe that colonoscopies
10 should always be performed in hospitals?

11 A. No, I don't.

12 Q. Why not?

13 A. Because I think that the available literature
14 shows that the complication rate for
15 colonoscopies is much lower than for, say,
16 induced abortions, especially abortion in the
17 second trimester, and most abortion --
18 second-trimester abortion procedures -- I'm
19 sorry, second abortion tri- --
20 second-trimester abortion procedures can
21 become very complicated very quickly.

22 Q. And you don't believe that a rupture of -- or
23 a perforation of a patient's colon can become
24 very serious very quickly?

25 A. I think that it can be, but I think that when

1 you look at complication rates and types of
2 complications, it -- including especially
3 where uterine perforation has occurred with
4 damage to vascular structures, perforation
5 has occurred with damage to bowel and
6 bladder, which I've personally had to care
7 for patients with those complications, the
8 rationale for doing those procedures in -- as
9 well as potential anesthesia complications,
10 the rationale for doing those procedures in a
11 hospital is re- -- is much clearer.

12 Q. As an obstetrician/gynecologist, if someone
13 had a perforation of their colon during a
14 colonoscopy, they would not ever be
15 transferred to your service for care,
16 correct?

17 A. No.

18 Q. Do you know the complication rate for
19 perforations in the course of a colonoscopy?

20 A. I would have to look at my declaration
21 because I believe that that was a question
22 that I discussed in my declaration. Would
23 you like me to do that?

24 Q. Sure.

25 A. Okay. Oh. Yeah. I did not put the

1 complication rates in here.

2 Q. Okay.

3 A. I think that what I had -- the point I was
4 trying to make in my declaration about
5 colonoscopy safety was that Dr. Farris cited
6 a paper to try to compare colonoscopy
7 complications to abortion complications, but
8 the particular paper that she cited did not
9 focus on colonoscopy complications. It was
10 looking at risk stratification to arrive at
11 an outcome measure so that outpatient
12 facilities could be profiled in terms of what
13 their rates of unplanned hospital visits
14 were. It did not have as its purpose the
15 estimation of overall incidence of
16 complication. So that was why -- that was
17 why I felt that that particular paper was not
18 speaking to the question of being able to
19 compare abortion complications with
20 colonoscopy.

21 Q. Understood. But you didn't then look for the
22 complication rate?

23 A. It was in the -- it was in the -- I'm sorry.
24 What -- what's your question?

25 Q. The -- that after -- in the course of

1 drafting your declaration, you did not look
2 up the --

3 A. Oh, no, I did.

4 Q. -- complication rate --

5 A. I did. I didn't put --

6 MR. BOYLE: Let -- let him finish the
7 question.

8 A. Oh, I'm sorry. Sorry. Sorry. Sorry.
9 Sorry.

10 Q. That's all right. So my question is, in the
11 course of your declaration, did you look up
12 the complication rate associated with
13 perforations during a colonoscopy?

14 A. Yes, I did.

15 Q. But you did not include that in your
16 declaration?

17 A. No. There was a lot of other ground to
18 cover.

19 Q. Do you know what the mortality rate of an
20 outpatient colonoscopy is?

21 A. No.

22 Q. Do you know what kind of sedation is
23 typically used in an outpatient colonoscopy?

24 A. Mild to moderate.

25 Q. And do you know if tissue is ever biopsied

1 during a colonoscopy?

2 A. Yes.

3 Q. And how would the person performing the
4 colonoscopy go about biopsying that tissue?

5 A. They use a hot snare.

6 Q. And what does that mean?

7 A. It's a either loop or -- or they -- they may
8 use a punch. They either use a loop or a
9 punch device to obtain a biopsy of what they
10 consider might be malignant tissue or even
11 nonmalignant if it's an adenoma -- I mean, a
12 polyp.

13 Q. And what is the process like of removing that
14 tissue or potential malignancy from the
15 colon?

16 A. As I said, they use a snare or they use a
17 biopsy forcep. They snip the biopsy and then
18 they -- if there's bleeding, they may or may
19 not cauterize it or they may use something
20 else to achieve hemostasis.

21 Q. So other than abortion clinics, do you know
22 whether North Carolina inspects outpatient
23 health centers that perform procedures or
24 surgeries?

25 A. I don't know for sure because I haven't

1 researched the information, but I do know
2 that ambulatory surgical centers have an
3 accreditation and inspection process.

4 Q. Are you aware of how frequently ambulatory
5 surgical centers receive notices of
6 deficiencies following those inspections?

7 A. No.

8 Q. Do you know what kind of sedation is provided
9 in outpatient surgical facilities in North
10 Carolina?

11 A. Ambulatory surgical centers?

12 Q. Yeah.

13 A. So at ambulatory surgical centers they have
14 anesthesiologists and anesthesiologists so they
15 provide the full gamut of anesthesia from
16 general anesthesia to sedation.

17 Q. So what is general anesthesia?

18 A. So general endotracheal anesthesia is where a
19 patient is paralyzed and intubated and the
20 ventilator breathes for them.

21 Q. And I believe you said deeper sedation.

22 A. Deep sedation.

23 Q. Deep sedation. What do you understand that
24 term to mean as you've used it in your
25 declaration?

1 A. It typically means that a patient will
2 receive a combination of barbiturate and --
3 b-a-r-b-i- -- okay. -- barbiturate and
4 narcotic and will put them into a state of
5 profound relaxation. They won't feel pain
6 and their breathing will slow. In general,
7 deep sedation is a procedure that should be
8 performed with an anesthetist or an
9 anesthesiology -- anesthesiologist present
10 because those patients can rapidly
11 decompensate and require intubation.

12 Q. And what do you understand moderate sedation
13 to be as you used that term in your
14 declaration?

15 A. The line -- the line between mild and
16 moderate simply means that the patient is
17 still able to breathe on their own and they
18 can often respond to you when you speak to
19 them, whereas, with deep sedation, they
20 usually can't. They have -- can maintain --
21 they can manage their secretions and breathe
22 on their own.

23 Q. And what medications are used to achieve this
24 level of sedation?

25 A. There's a wide variety.

1 Q. And I meant to ask earlier. What medications
2 are used to achieve general anesthesia?

3 A. There is a wide variety. I'm not an
4 anesথে- -- anesthesiologist.

5 Q. Okay. Do you know what kind of sedation is
6 provided to abortion patients at PPSAT's
7 clinics?

8 A. My understanding is that they provide mild,
9 moderate, and deep sedation according to
10 their own information.

11 Q. What information specifically are you
12 referring to?

13 A. Their protocols.

14 Q. When you say, protocols, can you be more
15 specific? How did you come to read these
16 protocols?

17 A. My understanding is that -- I believe that
18 she said in -- somewhere in -- one of --
19 Dr. Farris said in one of her declarations
20 that that's what they provide.

21 Q. So you have not seen anything produced by
22 PPSAT itself on this topic?

23 A. Yes, I have.

24 Q. Distinct from Dr. Farris's declaration?

25 A. Yes.

1 Q. How did you obtain those documents?

2 A. I was given to them -- I saw them through the
3 discovery process.

4 Q. In this case?

5 A. Yes. But I have seen them also in other
6 cases as well, in particular the Texas case,
7 and there was one other case where I'd seen
8 them as well.

9 Q. And you believe that the protocols in Texas
10 are comparable to the protocols in North
11 Carolina?

12 A. In general, my experience with Planned
13 Parenthood is that they seek to standardize
14 their procedures as much as possible across
15 different affiliates. So if I'm recalling
16 correctly, I had seen these in Texas and I
17 may have seen them in another case as well.
18 I just can't remember which one.

19 Q. Okay. Thank you. And do you know what kind
20 of medications PPSAT uses to achieve the
21 levels of sedation that they provide to their
22 abortion --

23 A. No.

24 Q. -- patients? Sorry. As -- I'm not sure that
25 the court reporter got your answer.

1 A. No.

2 Q. Thank you.

3 A. Yeah.

4 Q. So in Paragraph 180 of your declaration you
5 say that during the first six weeks of
6 pregnancy is when maternal morbidity and
7 mortality are highest.

8 Can you explain what you meant by that.

9 A. I think that what that is -- the -- I'm
10 referring to -- not referring to the entirety
11 of pregnancy; I'm referring to the first
12 trimester.

13 Q. Sorry. Can you just read that sentence that
14 begins, Deaths during.

15 A. It says, Deaths during the first six weeks of
16 pregnancy when maternal mortal- -- morbidity
17 and mortality are highest are kept classified
18 as maternal deaths and placed together with
19 deaths due to births and delivery.

20 Q. So you're not asserting that the first six
21 weeks of pregnancy are the most dangerous
22 part of the entire period of pregnancy, are
23 you?

24 A. No. What I'm saying is that the first six
25 weeks of the first trimester are the most

1 dangerous because that is typically when
2 ectopic pregnancies occur.

3 Q. And in Paragraph 238 of your declaration,
4 which I believe is on Page 41 in the upper
5 right-hand corner --

6 A. Yes.

7 Q. -- you say that, Carrying a pregnancy to term
8 is safer than an abortion.

9 Do you believe that that's true?

10 A. Yes.

11 Q. Do you -- as you mentioned earlier, you
12 submitted a declaration in a Minnesota case
13 in September of last year; is that right?

14 A. Yes.

15 Q. Okay.

16 MR. MENDIAS: And I'd like to mark that
17 as the next exhibit.

18 (WUBBENHORST EXHIBIT H, Declaration and
19 Expert Report of Monique Chireau Wubbenhorst,
20 M.D., M.P.H., Minnesota Case, was marked for
21 identification.)

22 MR. BOYLE: Thank you.

23 MR. MENDIAS: Thanks.

24 BY MR. MENDIAS:

25 Q. So on Page 10, Paragraph Number 47, can you

1 read that paragraph.

2 A. Yes. It is my opinion that without an
3 accurate estimate of the number of abortions
4 performed in the United States or the number
5 of maternal deaths from abortion, it is
6 impossible to estimate abortion-related
7 mortality with any precision.

8 Q. Do you agree that that's true?

9 A. Yes.

10 Q. If it is impossible to estimate the true
11 abortion-related mortality with any
12 precision, how are you now able to say that
13 abortion is more dangerous than childbirth?

14 A. Because if we look at the available data, and
15 the study I'm thinking of in particular is
16 the Bartlett study which shows that the risk
17 of death from abortion increases 38 percent
18 by every additional gestational -- week of
19 gestational age, that is not -- and that by
20 the end of midtrimester, the risk of death is
21 76 times greater than that -- than risk of
22 death in the first trimester. There is no
23 corresponding increase -- there is no
24 increase in risk in pregnancy that
25 corresponds to that risk.

1 And another study, I believe it was by
2 Lidiro, but don't quote me, found similarly
3 that there is a 30 percent increase in death
4 from abortion by -- with each additional
5 gestational week.

6 So what that says is that as you proceed
7 in gestation, the risks of abortion increase
8 exponentially, not just linearly but they
9 increase exponentially, and that is not the
10 case for mortality in pregnancy.

11 Q. Do you believe that people regularly obtain
12 abortions in pregnancy at the point in which
13 childbirth is most dangerous or in which
14 pregnancy is most dangerous?

15 A. Can you --

16 MR. BOYLE: Object to form.

17 A. I'm not sure I understand your question.

18 Q. That was a very confusingly worded
19 question --

20 A. Yeah.

21 Q. -- on my part. When do people typically
22 obtain abortions?

23 A. Well, this is an important question. Most
24 people -- so 93 percent of abortions in the
25 United States are performed -- 91 to 93

1 percent are performed before the first
2 trimester. And this is a significant problem
3 in ascertaining maternal complications and
4 death because the lar- -- much larger number
5 of abortions that are performed in the first
6 trimester when risk for mortality and
7 morbidity is lower basically drowns out all
8 of the additional morbidity and mortality
9 that's occurring in the second and third
10 trimester. We know that those abortions
11 occur because Warren Hern advertises on his
12 website that he does abortions up to 36 weeks
13 so we know that that happens. We know that
14 those occur.

15 We also know that simply based on
16 uterine and maternal physiology, the risk of
17 abortion at higher gestational ages is higher
18 and is not amenable to intervention because
19 the difference between a fetus at six
20 weeks -- an unborn child at six weeks and an
21 unborn child at 36 weeks is there's an
22 astronomical difference. You know, you're
23 talking about several grams -- 15 grams
24 versus eight -- you know, somewhere between
25 six and eight pounds. So I think that that's

1 the basis of that statement.

2 MR. BOYLE: Not immediately
3 necessarily, but can we take a break at some
4 point? It's been about an hour.

5 MR. MENDIAS: Sure. I'm -- if you
6 would like to take a break now --

7 THE WITNESS: Yeah, because you haven't
8 asked another question --

9 MR. MENDIAS: Sure.

10 THE WITNESS: -- so this might --

11 MR. MENDIAS: Okay.

12 THE WITNESS: -- be a good place.

13 MR. MENDIAS: Great.

14 THE WITNESS: Thank you.

15 THE VIDEOGRAPHER: Going off the
16 record. The time is 2:16.

17 (Whereupon, there was a recess in the
18 proceedings from 2:16 p.m. to 2:30 p.m.)

19 THE VIDEOGRAPHER: Back on the record.
20 The time is 2:30.

21 BY MR. MENDIAS:

22 Q. Doctor, during the break did you speak with
23 anyone about the deposition so far?

24 MR. BOYLE: Objection. To the extent
25 she spoke with me, that's work product and I

1 would instruct her not to divulge anything
2 that we spoke about.

3 BY MR. MENDIAS:

4 Q. Did you speak to anyone other than an
5 attorney --

6 A. No.

7 Q. -- during the break? Okay.

8 A. Well, I said hello to the front desk person.

9 Q. Did you consult -- did you consult any
10 studies or materials during the break?

11 A. No.

12 Q. So before we broke, you had mentioned
13 Dr. Hern. And your testimony was that he
14 performs abortions through 36 weeks; is that
15 right?

16 A. The last I saw on his website, yes.

17 Q. Does Dr. Hern practice in North Carolina?

18 A. No.

19 Q. Is abortion permitted through 36 weeks in
20 North Carolina?

21 A. No.

22 Q. If a woman is pregnant and is considering
23 whether to have an abortion or to carry to
24 term, isn't the relevant comparison for the
25 mortality associated with abortion at eight

1 weeks versus -- I'm sorry. I might have
2 omitted that from -- so I'll withdraw that
3 question.

4 If a woman is pregnant at eight weeks
5 and is considering an abortion, if she is
6 deciding between carrying to term and
7 delivering and having an abortion, isn't it
8 relevant for her to compare the mortality
9 associated with an abortion performed at
10 eight weeks with mortality associated with
11 childbirth?

12 A. No, it's not relevant at all.

13 Q. Why?

14 A. Because the mortality from abortion at eight
15 weeks -- the more relevant comparison would
16 be abortion at term or near term and maternal
17 mortality at the same gestational age.

18 Q. For that patient making the decision, you
19 believe that is the relevant comparison?

20 A. I guess I'm not understanding your question.
21 Are you saying that if -- if a woman is
22 looking -- wanting to understand what is
23 abortion-related mortality? Can you please
24 clarify?

25 Q. If a woman is eight weeks pregnant and is

1 deciding between continuing a pregnancy or
2 having an abortion at eight weeks --

3 A. Right.

4 Q. -- isn't it relevant for her to compare the
5 mortality associated with an abortion at
6 eight weeks with the mortality associated
7 with childbirth?

8 MR. BOYLE: Object to form.

9 A. So the mortality at eight weeks when the
10 fetus weighs 50 -- 15 grams is not applicable
11 or similar in any way to an abortion close to
12 term, as I said earlier, where the fetus
13 weighs five or six pounds, maybe seven
14 pounds. And abortion, as we've said, has a
15 38 percent -- the risks of mortality increase
16 exponentially, by 38 percent, for each week
17 of gestational age so I don't think that's an
18 accurate comparison.

19 I think the second problem with that
20 reasoning is that you cannot predict for any
21 given patient what their -- you know, risk is
22 a population-based assessment. It's not an
23 expression of whether an individual patient
24 will have an outcome or not. So you can't
25 say that, well, this patient had an abortion

1 and it kept her from having gestational
2 diabetes because you simply can't predict for
3 any individual patient with any certainty
4 that they will have a specific outcome.

5 Q. It's true that a person who has an abortion
6 will not suffer any complication from
7 pregnancy after that -- after the point in
8 which they had an abortion, correct?

9 A. Because you've performed the abortion and
10 they're no longer pregnant, but that's not
11 the point. The point of this discussion is
12 often that you can perform an abortion to
13 prevent maternal morbidity and mortality and
14 that's just not true. Number one, because we
15 know that where abortion is legal -- and the
16 specific examples that I'm aware of are Chile
17 during the Pinochet regime, Ireland, and
18 Malta. They had -- especially in Malta where
19 abortion is banned for any reason, they've
20 had zero maternal mortality for five years.
21 Same thing in Ireland. Ireland had one of
22 the lowest rates of maternal mortality in the
23 world prior to them legalizing abortion and
24 the same thing in Chile.

25 So it doesn't follow from that argument

1 that if you do an abortion, it's going to
2 lower maternal mortality or reduce maternal
3 morbidity.

4 Q. It's true that some women have preexisting
5 conditions that put them at very high risks
6 of negative outcomes during pregnancy,
7 correct?

8 A. Yes, that's correct. But you cannot say to
9 someone with diabetes, you're going to
10 develop diabetes and have a diabetic coma or
11 if you have high blood pressure, you're going
12 to develop preeclampsia and die. You simply
13 cannot do that. All of our assessments of
14 risk are population based; they are not
15 predictive for an individual.

16 Q. What is the risk that a woman with pulmonary
17 hypertension dies during pregnancy?

18 A. 50 percent.

19 Q. Do you believe a woman deciding whether or
20 not to have an abortion when she has
21 pulmonary hypertension might consider the
22 risk associated with abortion versus the risk
23 of a pregnancy in which there's a 50 percent
24 chance of dying?

25 MR. BOYLE: Objection and object to

1 form.

2 A. I guess --

3 MR. BOYLE: You can answer.

4 A. Okay. So your question -- let me just
5 rephrase your question back to you. So
6 you're saying that that woman should -- are
7 you saying that she should have the option to
8 have an abortion because she -- of her -- the
9 50 percent risk of mortality?

10 Q. That's a good question. Do you think that
11 she should?

12 A. I don't believe that abortion is -- elective
13 abortion is -- as -- as you've said before, I
14 don't agree with elective abortion. I think
15 that in the patient with pulmonary
16 hypertension, if she develops worsening
17 symptoms saying she could be delivered,
18 that's certainly an option.

19 Q. If a woman with pulmonary hypertension
20 becomes pregnant and not yet experienced any
21 negative outcome from her hypertension, you
22 don't think that she should be permitted to
23 have an abortion?

24 MR. BOYLE: Objection and object to
25 form. You can answer.

1 A. Yeah. I -- I -- I could not speak to that
2 situation. I think that, as I said, if she
3 became pregnant and she continued to carry
4 the pregnancy, she became symptomatic to the
5 extent that she needed to be delivered, then
6 that's an appropriate management plan.

7 Q. In Paragraph 196 of your declaration --

8 MR. BOYLE: Is this Exhibit B?

9 MR. MENDIAS: Yes.

10 A. Okay. Let me just read --

11 Q. Sure.

12 A. -- back so I can get context here. Okay.
13 Yes.

14 Q. Can you read the last sentence of that
15 paragraph.

16 A. In other words, the authors made estimates
17 for a substantial number of caseloads using
18 sources such as media stories which weakens
19 the validity of their study.

20 Q. Why do you believe re- -- relying on media
21 stories is inappropriate --

22 MR. BOYLE: Object to form.

23 BY MR. MENDIAS:

24 Q. -- in this context?

25 A. Because what we're talking about here is

1 epidemiology and epidemiology -- rather than
2 being based on what a media story says,
3 epidemiology ideally looks at patient-level
4 data.

5 Q. So in your report you provide the names of
6 women you say died following an abortion.
7 Did you have firsthand knowledge of any of
8 these women?

9 A. No.

10 Q. How did you first learn about these deaths?

11 A. I was, again, as I said earlier, looking at
12 data on abortion-related mortality and came
13 across the names of these women and I felt
14 that it was truly tragic that young, healthy
15 women underwent abortions that related --
16 resulted in their deaths.

17 Q. Did you find information about these women's
18 deaths in newspaper articles?

19 A. No. I found their -- can you just remind me
20 where that is?

21 Q. Sure. That is in Paragraph 188.

22 A. Yes. No. These were not -- I think in one
23 situation, it was -- the -- the first one, it
24 was a -- it was an article from the New York
25 Daily News.

1 Q. And in Subparagraph 7 you also cite the New
2 York Times, correct?

3 A. Yes.

4 Q. You also cite a website called
5 abortiondocs.org. Do you know what that is?

6 A. This was a website that had information, and
7 I believe this one had a autopsy report as
8 well.

9 Q. Do you know anything else about that website?

10 A. No.

11 Q. Did you review the medical charts of any of
12 these women?

13 A. No. I reviewed the autopsy reports as they
14 were presented on the internet.

15 Q. How many of them had autopsy reports?

16 A. I would have to count, but it looks like one,
17 two, three, four, five, six -- six or seven.
18 And then --

19 Q. Which --

20 A. -- the others had depos- -- were from a
21 deposition, another one was from an EMS
22 report, and two were from -- oh, I just saw
23 the numbers are out of order. Okay.

24 Q. Did any of the autopsy reports or articles
25 that you consulted detail the women's medical

1 histories?

2 A. Yes.

3 Q. Which ones?

4 A. All of the autopsy reports. That's routine
5 with autopsy reports.

6 Q. Do you know how much time elapsed between the
7 abortion procedure and the complications --

8 A. I would have to look at --

9 Q. -- each women suffered?

10 A. -- each -- I would have to look at each one.
11 I'm sorry. Sorry. Did not mean to cut you
12 off.

13 Q. Are you aware of any women who died following
14 second-trimester abortions in hospitals?

15 A. Yes. I think I mentioned a couple of those.

16 Q. Can you specify which ones occurred in
17 hospitals?

18 A. I believe Keisha Atkins did and I believe --
19 in fact, I'm pretty sure -- I would have to
20 look at the autopsy reports but -- I believe
21 that most of these women died in hospital,
22 but I would have to confirm that.

23 Q. Oh, I'm sorry. My question was, do you know
24 if any of the abortions were performed in
25 hospitals?

1 A. I think that information was in the autopsy
2 reports, but I would have to reread them.

3 Q. But you didn't include any of that
4 information in the declaration, did you?

5 A. No.

6 Q. Do you know how many abortions were performed
7 at the clinics where these patients received
8 their abortions?

9 A. No.

10 Q. Throughout your report you cite studies that
11 suggest that a woman is at a high risk of
12 suicide following abortion; is that right?

13 A. I think that the more precise way of
14 expressing it is that there is evidence that
15 in- -- there are increased risks for suicide
16 among women who've undergone abortion.

17 Q. So to be clear, you're not arguing that
18 abortion causes suicidality?

19 A. I would say that more accurately that there
20 is an association between abortion and
21 suicidality, yes.

22 Q. And so what is an association?

23 A. Association can be positive or negative, but
24 it does not necessarily -- to -- it doesn't
25 address the issue of causality. It's a -- it

1 indicates that there is an association.

2 Q. Is an association synonymous with a
3 correlation?

4 A. Not exactly, no.

5 Q. How do they differ?

6 A. Correlation means that you compare one set of
7 outcomes or one set of values with another to
8 see if the relationship is linear or colinear
9 or nonlinear so it's a -- it's a slightly
10 different -- slightly different way of
11 approaching it.

12 An association is simply that you can
13 have a positive or a negative association
14 between an exposure and an outcome.

15 Q. Doctor, what is the American Psychological
16 Association, if you know?

17 A. The APA? Yeah.

18 Q. Correct.

19 A. It's an association of -- I don't know -- I
20 know of the organization's existence. I
21 don't know whether they are the same as ACOG
22 or as a professional society. I can't speak
23 to that.

24 Q. Do you believe that they're a reliable
25 source?

1 A. I can't speak to that either. I do know that
2 they've engaged in considerable abortion
3 advocacy starting in 1979.

4 Q. What makes you describe their -- what makes
5 you describe what they do as advocacy?

6 A. One of their statements that they made in
7 1979 was that they felt that abortion was --
8 and I'm paraphrasing. I would have to look
9 at the exact quote. But they made statements
10 strongly supporting abortion.

11 Q. Do you believe that a statement either in
12 favor of or in opposition to abortion is
13 necessarily advocacy?

14 A. I think it depends on how you define
15 advocacy.

16 Q. How would --

17 A. I think on some level, what it means is
18 that -- when an organization engages in
19 pro-abortion statements, it means that it's
20 worth looking very carefully at their
21 statements and the particular conclusions
22 they draw regarding abortion.

23 Q. Do you believe the same applies to
24 organizations that oppose abortion?

25 A. Yes. I think that you have to look at the

1 quality of the science that they're proposing
2 and I think that in some studies, for
3 example, because this is a contentious topic,
4 some researchers will -- will look -- will
5 provide -- will look at both -- will look at
6 what's called the null hypothesis, which is
7 in their research to say, you know, we're --
8 we're not going to assume a benefit or a
9 risk; we're just going to approach this
10 agnostically to try to account for that.

11 Q. Do you consider yourself an advocate?

12 A. No. I would say my advocacy more falls in
13 terms of scientific advocacy.

14 Q. But you would describe yourself as a
15 scientific advocate then?

16 A. No, I would not. I would say that I am
17 interested in looking at the science,
18 critiquing the science, and applying the
19 science appropriately.

20 Q. But you engage in advocacy?

21 A. I don't engage in formal advocacy efforts as
22 in -- I think I would -- if you can define
23 what you mean by advocacy, that would help me
24 to answer the question.

25 Q. All right. Well, earlier, in response to one

1 of my questions you referred to, my advocacy,
2 and so I'm just wondering what you mean by
3 that.

4 A. I'm -- I'm sorry. I don't remember -- if she
5 can read the question, that would be helpful.

6 Q. Sure.

7 MR. MENDIAS: Would you mind doing
8 that, Lisa?

9 (The following question and answer were
10 read back:

11 Q: Do you consider yourself an
12 advocate?

13 A: No. I would say my advocacy more
14 falls in terms of scientific advocacy.)

15 A. Right. So what I would say is that my
16 advocacy is for women and children. That's
17 what I'm about. To the extent that that
18 impinges on the question of abortion, yes,
19 but I've devoted my career and my life to
20 serving women, especially vulnerable women,
21 vulnerable children, women in socioeconomic
22 deprivation and otherwise. So that's the
23 source of my advocacy and the reason for it.

24 Q. Have you ever testified before Congress on a
25 topic unrelated to abortion?

1 A. No.

2 MR. MENDIAS: All right. So I'm going
3 to mark this as an exhibit.

4 (WUBBENHORST EXHIBIT I, Article, The
5 facts about abortion and mental health,
6 American Psychological Association, was
7 marked for identification.)

8 MR. BOYLE: Thank you.

9 MR. MENDIAS: Thanks.

10 BY MR. MENDIAS:

11 Q. And so this is the APA, and it has said that,
12 More than 50 years of international
13 psychological research shows that having an
14 abortion is not linked to mental health
15 problems, but restricting access to safe,
16 legal abortions does cause harm.

17 You consider that statement to be
18 advocacy, correct?

19 A. I'm sorry. I -- I started reading it.

20 Q. Oh, apologies.

21 A. Distract- -- got distracted.

22 Q. I'm sorry.

23 A. Yeah. Go ahead.

24 Q. You would consider the statement -- I -- I --
25 I'm sorry. I'll -- I'll read the statement

1 again. More than 50 years of international
2 psychological research shows that having an
3 abortion is not linked to mental health
4 problems, but restricting access to safe,
5 legal abortions does cause harm.

6 Do you believe that that conclusion is
7 advocacy?

8 A. I can't speak to that because I don't know
9 the intent of the person saying it. I can
10 say that I disagree with that statement.

11 Q. Are you aware that the APA has cited large
12 longitudinal and international studies which
13 have found that obtaining a wanted abortion
14 does not increase risk for depression,
15 anxiety, or suicidal thoughts?

16 MR. BOYLE: Objection.

17 A. I am not -- I haven't -- I haven't seen this
18 particular -- this particular document so I
19 can't really comment on it. When I look at
20 this -- documents like this, I need to look
21 at the studies they're citing, critique their
22 statistical methods, and so on and so forth
23 so I can't really speak to that.

24 Q. That's fair. Are you familiar with the
25 Turnaway Study?

1 A. Yes.

2 Q. And what is it?

3 A. So the Turnaway Study was a study -- was a
4 survey of women who had undergone abortion at
5 differing intervals over -- out to five years
6 and looked at various outcomes associated
7 with the women who -- women who remained in
8 the study until the -- the end of the study.

9 Q. And would you agree that it was extremely
10 well-designed?

11 A. Yes. I think I've stated that, actually.

12 Q. And --

13 A. But the best design can't overcome the
14 vagaries of surveys. Survey data is the
15 weakest form of data as opposed to
16 observational studies, clinical trials, and
17 others.

18 Second of all, the Turnaway Study, as
19 I've said, while it was well-designed, had
20 very significant dropoff to the extent that
21 only 19 percent of patients finished.

22 And more to the point, by the end of the
23 study, if you look very carefully at the
24 data, 95 percent of women who kept their
25 children said they were happy with their

1 decision.

2 Q. Are you aware of the comparable percentage of
3 women who reported life satisfaction after
4 they had obtained abortions?

5 A. The comparable percent?

6 Q. (Nods head).

7 A. I would have to look at it again. I think I
8 cited it in my -- but I think -- again, I
9 would like to come back to the point that the
10 methodological problems associated with
11 Turnaway Study are very significant.

12 Another important issue, and forgive me
13 if this is not the most current data, is that
14 people have repeatedly requested Turnaway
15 Study -- the authors to put their data in a
16 data repository and to date, as far as I
17 know, they've refused to do that.

18 Q. Do you know whether there were any
19 significant differences between the women who
20 continued in the study and those who were
21 lost to follow-up?

22 A. Yes. I think that if you look at the
23 study -- and I would have -- it would be
24 great if I could refer to my -- oh, actually,
25 I don't know if I went into a detailed

1 critique here. There were differences in
2 gestational age at the time of abortion
3 versus no abortion. And, again, the -- the
4 question really is that if only one in five
5 patients at the end of a study stayed in the
6 study, no matter how well-designed it was --
7 and I think it was -- it was a very
8 well-designed study, asked a lot of
9 questions, but that cast doubt on the
10 validity of the study simply based on the
11 lack of follow-up.

12 Q. Do you believe that that's true even if there
13 were no meaningful differences between the
14 women who were lost to follow-up and the
15 women who stayed in the study?

16 A. You can't make any conclusions. If one --
17 only one in five patients stayed till the
18 end, you simply cannot draw conclusions.

19 Q. Are you familiar with a 2018 report published
20 by the National Academies of Science,
21 Engineering, and Medicine concerning the
22 safety of abortion in the United States?

23 A. Yes.

24 Q. So in your declaration you criticize it for
25 being funded by abortion advocates; is that

1 correct?

2 A. Yes.

3 Q. Do you believe that a study should be
4 discounted on the basis that the people who
5 funded it have a strong political view of
6 abortion?

7 A. No. I think that that means that you should
8 scrutinize the methods and the results more
9 carefully.

10 Q. Are you familiar with the criteria that the
11 National Academies used in deciding whether
12 to include a study in its review?

13 A. Yes. And I think that they eliminated a vast
14 number of studies that were -- would have
15 spoken to the issue and ended up with a very
16 small amount -- very small number of studies
17 that did not accurately reflect the
18 literature.

19 They also continued to discuss this
20 statistic of, you know, women are more -- 12
21 to 14 times more likely to die in childbirth
22 when preg- -- than from abortion when that
23 statistic is based on a paper by Raymond and
24 Grimes which has severe methodological
25 problems. It combines different data sets.

1 It uses different denominators. It does not
2 use -- does not account for the majority --
3 I'm sorry. -- does not account for
4 differences in -- in those databases.

5 So, again, I -- I would have to say that
6 on the merits, the National Academy study
7 suffers from one of the typical problems of
8 systematic evidence reviews and metaanalyses,
9 which is that they're very dependent on what
10 criteria you use for your metaanalysis and
11 how biased those studies are or are not.

12 Q. You -- I believe the answer was, yes, you are
13 familiar with the criteria that the National
14 Academies used so can you say what criteria
15 those are.

16 A. I would have to look to be precise.

17 Q. But when you say you're familiar, you have a
18 general sense of what they used to exclude or
19 include studies?

20 A. Yes. I think that what they -- they used in
21 their metaanalysis, they used metaanalytic
22 rules that -- again, I would have to look at
23 the study to be precise because I don't want
24 to misquote them. But they -- through their
25 process, the point is that their rules

1 excluded a very large number of studies that
2 were responsive to the question.

3 Q. Do you believe that they excluded only
4 studies that showed a -- a -- an association
5 with negative outcomes and abortion?

6 A. I'm not following your question.

7 Q. Do you believe they --

8 A. Will you rephrase, please.

9 Q. Sure. They -- do you believe that they
10 excluded studies that showed no negative
11 outcomes associated with abortion?

12 A. Studies that showed no negative -- I -- I
13 would have to go back and look at the studies
14 they excluded. I can't say off the top of my
15 head.

16 Q. Can you give an example of one criterion that
17 they used to exclude studies?

18 A. Again, I don't want to misquote. I have read
19 the study in great detail and critiqued its
20 methods, but if you want me to pull up the
21 study and look at it, if you have a copy of
22 it, I'm happy to do that.

23 Q. I don't so we can continue.

24 A. Yeah.

25 Q. In your report you cite a 2009 Finnish study

1 by Niinimäki, which is N-i-i-n-i-m-a-k-i,
2 called, Immediate Complications After Medical
3 Compared With Surgical Termination of
4 Pregnancy.

5 A. What -- what paragraph is that?

6 Q. So that would be Paragraph 32. And did you
7 bring a copy of that study? I forget if that
8 was one of the ones that you said you had.

9 A. No, I didn't bring one.

10 Q. So just give me a moment.

11 MR. MENDIAS: I'm going to mark this as
12 well.

13 (WUBBENHORST EXHIBIT J, Article,
14 Immediate Complications After Medical
15 Compared With Surgical Termination of
16 Pregnancy, was marked for identification.)

17 MR. BOYLE: Thank you.

18 MR. MENDIAS: Uh-huh.

19 BY MR. MENDIAS:

20 Q. And in Paragraph 32 you cite this study in
21 support of your claim that first-trimester
22 medication abortion carries substantial risks
23 to the mother; is that right?

24 A. Yes.

25 Q. And are you aware what sorts of medication

1 abortion regimens patients had received in
2 this study?

3 A. Yes. I think that they used vaginal
4 misoprostol, which is somewhat different from
5 the regimen that's used in the United States;
6 however, there have never been any
7 head-to-head trials to show that that regimen
8 is less safe or more safe or -- there have
9 been -- never been any effectiveness or
10 efficacy trials to compare those two.

11 Q. So I'm going to direct you to a particular
12 paragraph. So on Page 796, the first
13 paragraph of the column on the right side, do
14 you see the sentence after Footnote 14 that
15 begins, The time of follow-up?

16 A. Yes.

17 Q. Would you please read that sentence.

18 A. The time of follow-up after abortion was 42
19 days.

20 Q. Then could you read the next sentence as
21 well.

22 A. Medical abortion was defined as the use of
23 mif- -- mifepristone alone or in combination
24 with misoprostol or other prostaglandins.

25 Q. So do you know whether PPSAT uses a

1 medication abortion regimen different from
2 those methods?

3 A. I think PPSAT does use a -- an abort- -- a
4 regimen that's different. But, again, as I
5 said earlier, there's never been a
6 head-to-head comparison to show that the
7 efficacy, safety, or effectiveness of this
8 regimen differs from the one used by PPSAT.

9 Q. Okay. And so returning to the first page,
10 can you read the paragraph after the all caps
11 word conclusion.

12 A. Both meso- -- methods of abortion are
13 generally safe, but medical termination is
14 associated with a higher incidence of adverse
15 effects. These observations are relevant
16 when counseling women seeking early abortion.

17 Q. So are you aware that the authors later
18 explained that the study was based on a
19 Finnish health registry that coded all
20 follow-up visits as complications even if
21 those visits were just for additional
22 consultation?

23 A. Yes, I'm aware of that, but I don't think
24 that's relevant to the point that I was
25 trying to make. The point that I was trying

1 to make was that the risk of hemorrhage was
2 very significant. It was almost 16 percent.
3 So the risk of incomplete abortion was 6.7
4 percent and 1.6 percent with surgical
5 abortion. And the risk of emergency surgery
6 was also close to 6.7 -- 6 percent.

7 So the point I was trying to make was
8 not the study design. It was the fact that
9 these hard outcomes that they looked at
10 including hemorrhage, including need for
11 surgical evacuation, in- -- including risk of
12 incomplete abortion, were higher than
13 surgical abortion and higher than what's
14 reported in the United States.

15 Moreover, I want to emphasize that these
16 Finnish studies have the advantage of
17 complete ascertainment, which we do not have
18 in the United States ever. They track every
19 woman from birth -- every human being from
20 birth until death, all of their interactions
21 with the medical system, so this is a
22 comprehensive way of looking at all tort --
23 tor- -- sorts of medical outcomes. I've
24 spoken with Mika Gissler. The research that
25 they do is really excellent and that's the

1 point I was trying to make.

2 MR. MENDIAS: So I'm going to mark
3 this.

4 (WUBBENHORST EXHIBIT K, Letters to the
5 Editor, Immediate Complications After Medical
6 Compared With Surgical Termination of
7 Pregnancy, was marked for identification.)

8 MR. BOYLE: Thank you.

9 BY MR. MENDIAS:

10 Q. Doctor, you mentioned hemorrhage. In the
11 second paragraph on -- in the leftmost
12 column, do you see a sentence in the middle
13 of that paragraph that begins, Based on?

14 MR. BOYLE: Objection. What -- what
15 are we looking at here?

16 BY MR. MENDIAS:

17 Q. This is -- do you rec- -- do you recognize
18 this publication that --

19 A. Yes. Uh-huh.

20 Q. Okay. Do you see the paragraph -- the second
21 paragraph in the leftmost column?

22 A. Yes.

23 Q. And do you see the sentence about halfway
24 through that begins, Based on?

25 A. Uh-huh.

1 Q. Could you --

2 MR. BOYLE: Objection. Can we -- can
3 we just clarify what it is on the record,
4 please.

5 BY MR. MENDIAS:

6 Q. All right. Can you say what this document
7 is.

8 A. Oh, this is a letter to the editor from --
9 I'm familiar with this. -- I think her name
10 is Mary Fjerstad to the editors of The Green
11 Journal OB/GYN asking -- presenting some
12 questions for the authors.

13 Q. Okay. And can you read that sentence we were
14 just talking about.

15 A. Based on correspondence with the Dr. --
16 H-e-i-k-i-n-h-e-i-m-o, one of the authors of
17 the Niinimäki -- I'll spell that,
18 N-i-i-n-i-m-ä-k-i, and there's an umlaut over
19 the A -- in Finnish health registries, any
20 return visit, even for additional
21 consultation, is categorized as a
22 complication. Thus, a woman who is bleeding
23 may have been within the normal range but who
24 sought reassurance could have been coded as
25 having had a hem- -- hemorrhage.

1 Q. So isn't it true that the rates of hemorrhage
2 might have been inflated in the original
3 Niinimäki study?

4 A. I don't think that's true. This author is
5 making a presumption not based on any data.
6 She said a woman may -- her bleeding may have
7 been in the normal range and could have been
8 coded, but she doesn't present any data or
9 any critique of the data to support that
10 statement.

11 Q. And the doctor she refers to, Heikinheimo, he
12 was a -- an coauthor of the 2009 --

13 A. Right.

14 Q. -- Niinimäki story -- or article?

15 A. But they don't present the correspondence so
16 I can't comment on that.

17 Q. How do you define hemorrhage?

18 A. It depends on the procedure. So typically,
19 you can have as much as -- I mean, again, it
20 depends on the procedure.

21 Q. Is any amount of bleeding in a patient
22 hemorrhage?

23 A. No.

24 Q. So how much bleeding is a minimum to be
25 considered hemorrhage?

1 A. It's usually prespecified in patients and in
2 clinical data so that's why I'm asking you
3 which procedure you're referring to. For
4 example, if it's a labor-and-delivery
5 patient, we would consider bleeding up to
6 about 400 milliliters to be normal and then
7 once past that, maybe 3- to 400, and then
8 once it's beyond that, we count that as
9 postpartum hemorrhage. So it's procedure
10 specific and in papers, as I said, they
11 usually provide a predefined cutoff as to
12 what they consider to be hemorrhage.

13 Q. How much bleeding is considered hemorrhage in
14 a medication abortion patient?

15 A. I think that it's -- they can bleed as much
16 as 80 to 100, but, again -- 100 is --
17 milliliters. But, again, the amount is
18 subjective. And unless you weigh pads, which
19 is what we do -- weigh pads and surgical
20 sponges and so on and so forth, which is what
21 we do with hemorrhage at term, it is
22 difficult to quantify.

23 Q. And in the right column of this letter to the
24 editor page, this was written by the authors
25 of the study, Niinimäki 2009, et al.,

1 correct?

2 A. Yes.

3 Q. And can you read the bullet point at the
4 bottom of that rightmost column on the first
5 page.

6 A. Rate of serious real complications is rare
7 and rather similar between surgical and
8 medical abortion.

9 Q. And was the 2009 Niinimäki study a
10 retrospective administrative database study?

11 A. Yes.

12 Q. And you say a strength of that study is to
13 completely ascertain all abortions and all
14 complications, correct?

15 A. Yes.

16 Q. But in your declaration at Paragraph 36, you
17 criticize a study by Upadhyay, et al., from
18 2015.

19 A. Yes.

20 Q. And you specifically say that it has many
21 limitations similar to other retrospective
22 administrative database research studies,
23 correct?

24 A. Yes. That's because studies that are done in
25 the United States cannot have complete

1 ascertainment. We don't have the types of
2 databases, we don't have the types of
3 registration, we don't have the types of
4 statistical methodology and power that they
5 do in Scandinavia so they're not com- --
6 comparable at all.

7 Q. But didn't Upadhyay in the 2015 study look at
8 Medicaid data which included all Medicaid
9 beneficiaries who had received an abortion
10 and any follow-up care that they obtained?

11 MR. BOYLE: Objection. You can answer.

12 A. They're -- the Medicaid databases are
13 notorious. I've worked extensively -- you
14 can look at my CV and see that I have two,
15 maybe three papers looking -- doing heavy
16 power lifts using Medicaid data. Medicaid
17 data is notorious for being limited. There
18 is miscoding. There are patients that, for
19 example, will code for having two deliveries
20 in one year. The ability to -- for them to
21 follow up on patients is -- is not -- it is
22 not comparable in any way to what the Finnish
23 people can do with their databases.

24 And in addition to that, the Finnish
25 database is designed to capture both medical

1 and administrative and financial data.
2 Medicaid is designed just to capture
3 financial data. That's it. It's -- it is
4 not -- and it doesn't have information on
5 gestational age, doesn't have information on
6 complications at the patient level. These
7 databases do.

8 Q. So looking back at the reply that Niinimäki
9 wrote in response to Mary Fjerstad's letter
10 to the editor, isn't it true that she writes
11 that complications -- many of the
12 complications are not really such but,
13 rather, concerns or adverse events that bring
14 women back to the healthcare system?

15 A. Yes. That's what she says.

16 Q. Does that imply that there was some
17 miscoding?

18 MR. BOYLE: Objection.

19 BY MR. MENDIAS:

20 Q. You can answer.

21 A. No, I don't think that there's miscoding
22 because, as I've said, they organize their
23 database very differently from ours and
24 miscoding is very rare if -- and unusual.

25 What I would say is that the specific

1 outcomes that I mentioned, which were
2 hemorrhage, incomplete abortion, and
3 emergency surgery, are hard outcomes and they
4 were demonstrated to be more common and they
5 were demonscra- -- -strated to occur at a
6 specific incidence or prevalence within a
7 population that we were looking at.

8 Q. And you also criticized the 2015 Upadhyay
9 study saying that, There is a likelihood that
10 patients with complications didn't engage
11 with the medical system; is that right?

12 A. Yes. And what I meant by that was that they
13 did not engage with the medical system in a
14 way that was visible through a Medicaid
15 administrative database. That's the point
16 that I was trying to make. If a patient had
17 complications, of course, they would
18 reasonably engage with the medical system,
19 but the fact of the matter is that what we
20 find very frequently is that when patients
21 suffer abortion complications, they do not
22 return to the abortion clinic. They are seen
23 by physicians like myself who go to hospital
24 emergency rooms and that was the point that I
25 was trying to make, that they did not engage

1 with the medical system in a way that was
2 visible through a Medicaid database.

3 Q. In Paragraph -- my -- my apologies. So in
4 general, you criticize record linkage study
5 involving the Medicaid program.

6 Is that a fair representation of your
7 position in the declaration?

8 A. I think it's open to critique, but sometimes
9 it's the data that we have. But I do think
10 that it is not adequate to answer certain
11 questions and that's what I'm -- the point
12 I'm trying to make.

13 Q. So in Paragraph 57 of your declaration you
14 cite a study by Reardon, et al., from 2002.

15 A. Uh-huh.

16 Q. That was also a California Medicaid record
17 linkage study, correct?

18 A. Right. Yes.

19 Q. Would you agree that the 2015 Upadhyay study
20 was well-designed?

21 A. I would have to go back and look at the study
22 design because I cannot say off the top of my
23 head whether it was well-designed or not. I
24 don't believe I commented on the study
25 design. I said there were methodologic

1 issues, but I didn't say whether it was
2 well-designed or not well-designed.

3 Q. So do you have your Minnesota expert report?
4 And I'm -- apologies. I do not remember what
5 exhibit it was marked as.

6 MR. BOYLE: H.

7 BY MR. MENDIAS:

8 Q. H. So --

9 A. Oh. Oh. Oh. You already --

10 Q. Yeah.

11 A. -- gave it. Okay.

12 Q. Yeah.

13 A. Wait a minute. Wait a minute.

14 Q. So on Page 16 -- or -- I'm sorry. Yes.
15 Actually, Page 16, Paragraph 71. And that
16 would be the fifth line of that paragraph.

17 A. Yes.

18 Q. You did say it was well-designed, correct?

19 A. Yes.

20 Q. Okay.

21 A. Uh-huh. And in Paragraph 143 you also
22 criticize another Upadhyay study.

23 MR. BOYLE: Object to form. What --
24 what exhibit are you on now?

25 MR. MENDIAS: It's -- I haven't marked

1 that exhibit yet. I'm talking about her
2 declaration.

3 A. But you didn't tell me which --

4 MR. BOYLE: So you're back to --

5 A. -- document --

6 MR. BOYLE: -- Exhibit B?

7 A. -- we're referring to.

8 Q. No. No. No. I -- this is another Upadhyay
9 study and I will mark that, but I haven't
10 marked it yet. So --

11 MR. BOYLE: But you're back in
12 Exhibit B --

13 MR. MENDIAS: Oh, in Exhibit B --

14 MR. BOYLE: -- 4- --

15 MR. MENDIAS: -- yes. Correct.

16 THE WITNESS: Okay.

17 MR. BOYLE: -- Paragraph 143?

18 MR. MENDIAS: Apologies. Yeah.

19 MR. BOYLE: Yeah. Thank you.

20 BY MR. MENDIAS:

21 Q. So Paragraph 143 of your declaration. So in
22 the --

23 A. Yes. Uh-huh.

24 Q. So that was a 2018 Upadhyay study?

25 A. Uh-huh. And I just want to say, I have

1 nothing against Dr. Upadhyay.

2 Q. Sure. You point out that it only included
3 data from 15.7 percent of the country.

4 MR. BOYLE: Objection.

5 BY MR. MENDIAS:

6 Q. You can answer.

7 A. I think that what I said was that it's 15.7
8 percent of hospitals.

9 Q. Sure.

10 A. And then I went on to say, quote -- quote, It
11 undersampled some regions west and south and
12 oversampled others.

13 Q. Do you have a reason to believe that abortion
14 complications are more likely in some regions
15 of the country than others?

16 A. Yes.

17 Q. What would those reasons be?

18 A. I think that the -- actually, not the
19 complications themselves. I can't really
20 comment on whether the complications
21 themselves would be more likely in different
22 parts of the country, but the management of
23 those complications might depend on the
24 availability of health services.

25 Q. And so with respect to your criticism that it

1 only included 15.7 percent of hospitals in
2 the country, are you aware of any data set
3 that includes emergency room data from every
4 hospital in the United States?

5 A. I think there are data sets like that that
6 exist, but I would have to confirm that.

7 Q. You've never -- you couldn't provide a name
8 of such a data set?

9 A. It would be very easy to get that.

10 Q. Okay. Who do you think maintains this data
11 set?

12 A. I think the Hospital Association of America
13 has similar data sets. Again, I can't really
14 comment on which ones they are or who
15 maintains them, but I know that they exist.

16 Q. So the authors of that study say they used
17 data from the nationwide emergency department
18 sample.

19 Are you familiar with what that is?

20 A. Yes.

21 Q. What is it?

22 A. It is a sampling -- but it's not a random
23 sampling. It's a sampling of emergency
24 department encounters with -- from patients
25 with the medical system through the emergency

1 department.

2 Q. And they also, the authors, that is, say that
3 that sample is maintained by the Agency for
4 Healthcare Research and Quality.

5 Are you familiar with that --

6 A. Yes.

7 Q. -- agency? What is that agency?

8 A. HRQ is an agency of the Federal Government
9 that looks at -- its mandate is health
10 services research in the United States.

11 Q. Do you believe that it's a reliable source of
12 data?

13 A. It's reliable to the extent that -- of the
14 data's quality. No source is reliable in and
15 of itself; it depends on data quality and
16 integrity.

17 Q. Do you believe that the data from the
18 national emergency department sample is of
19 low quality?

20 A. I haven't reviewed it and I can't really say.

21 Q. You note as well in your declaration that 15
22 deaths were noted in the Upadhyay 2018 study;
23 is that right?

24 A. Can you direct me to where -- where you
25 are --

1 Q. Sure. That's --

2 A. -- referring to?

3 Q. -- Paragraph 146.

4 A. It says -- yes. It says, 15 patients in the
5 sample had ED visits that ended in the
6 patient's death.

7 Q. Are you aware what the total sample size was?

8 A. I would have to look at the paper, but I was
9 not using that statistic as the numerator for
10 an assessment of deaths from abortion. That
11 was not the purpose. The point I was trying
12 to make is that patients present to the
13 emergency room and died in the emergency
14 room. That was the point I was making. I
15 was not making an epidemiologic assessment
16 that this is the numerator over some
17 denominator of encounters in the ER. That's
18 not what I was trying to do.

19 Q. What was the relevance of the point you were
20 trying to make?

21 A. That patients presented to the emergency room
22 and died in the emergency room.

23 Q. Isn't it possible that if a woman did not
24 disclose that she had had an abortion, she
25 would have been excluded from the study

1 sample?

2 A. It's possible, but that's speculation.

3 Q. But you believe that abortion providers tell
4 their patients not to inform emergency
5 departments staff that they've had an
6 abortion?

7 A. I don't believe it, but I believe that I've
8 documented in my declaration where that has
9 occurred.

10 Q. Has it occurred in North Carolina?

11 A. I don't know.

12 Q. Have you ever seen anything from PPSAT to
13 suggest that it tells its patients such a
14 thing?

15 A. I would not say that. I have not seen that.

16 Q. In Paragraph 67 of your declaration --

17 A. Okay. Give me just a minute here.

18 Q. Sure.

19 A. Yes.

20 Q. -- you assert that aspiration abortion is
21 surgery.

22 A. Yes.

23 Q. And in the next paragraph you say, It
24 requires surgical training distinct from
25 other types of training.

1 A. Yes.

2 Q. Is that training that you've received?

3 A. No. But as an academic physician, I was
4 aware of and continue to be aware of the fact
5 that physicians who are being trained to do
6 abortions are trained in surgical technique
7 of doing abor- -- performing abortion.

8 Q. Do you consider a D&C to be a form of
9 surgery?

10 A. Yes.

11 Q. In Paragraph 69 you say, It requires surgical
12 operative sterile technique. What do you
13 mean by that phrase?

14 A. What are we referring to?

15 Q. In Paragraph 69 you say, It requires --

16 A. When you say -- are you referring to surgical
17 abortion?

18 Q. Well, I -- I'm asking about the paragraph
19 that you wrote so I'm wondering what the it
20 is there and --

21 A. Right.

22 Q. -- what you mean --

23 A. So it's surgical --

24 Q. -- by that phrase.

25 A. -- abor- -- oh, sorry. Sorry. I'm sorry.

1 Q. No. Go ahead. I -- I'm asking you to
2 explain that paragraph in -- both in terms of
3 what it's referring to and what you mean by
4 surgical operative sterile technique.

5 A. So when surgery is performed, typically, we
6 perform surgery using instruments that have
7 undergone high-level sterilization to prevent
8 the introduction of spores and resistant
9 organisms into body cavities. That is part
10 of operative technique. We also use sterile
11 gloves, sterile gowns, sterile instruments,
12 and sterile conditions, sterile surfaces, and
13 that defines what sterile operative technique
14 is.

15 Q. And what is curettage?

16 A. It's French because many of our medical terms
17 are from French or Greek and it means
18 scraping.

19 Q. Can you explain how that scraping constitutes
20 a, quote, linear incision through the lining
21 of the uterus, end quote, as you assert in
22 Paragraph 71 of your report.

23 A. Because when you perform an abortion or when
24 you are doing dilation and curettage for
25 retained products of conception, you apply

1 the curette until you hear something called a
2 cri, c-r-i, and what that is is the sound of
3 you scraping through the layer of the uterus
4 to make linear incisions in the endometrium,
5 the lining of the uterus, down to the
6 beginning of the -- down to the interface
7 between the muscle -- the -- what's -- down
8 to the base of the endometrium. And that is
9 characteristically a gritty sensation that
10 you encounter and that tells you that you've
11 removed the tissue either through an
12 incomplete abortion or whatever procedure
13 you're doing.

14 Q. And do you consider that scraping to be an
15 incision?

16 A. It is because you're incising through the
17 lining of the uterus.

18 Q. Are you aware that ACOG does not describe
19 curettage as involving an incision?

20 A. I'm aware that ACOG makes that distinction.
21 I don't agree with that.

22 Q. In Paragraph 74 of your declaration you
23 suggest that, 15 to 20 percent of patients
24 receiving curettage due to an induced or
25 spontaneous abortion develop intrauterine

1 adhesions, correct?

2 A. I didn't say that. I quoted these authors as
3 saying that.

4 Q. And you agree with that statement?

5 A. Yes.

6 Q. What is a spontaneous abortion?

7 A. It's a miscarriage where you have in utero
8 fetal demise.

9 Q. So the figure that you cite doesn't
10 differentiate between those patients who
11 miscarried and those who obtain an abortion
12 and then subsequently developed intrauterine
13 adhesions, correct?

14 A. In the paper and in subsequent papers they do
15 make that distinction. The point I was
16 trying to make there is that curettage is
17 surgery and it leads to surgical
18 complications. It leads to scar tissue.

19 Q. And like you said, you've performed D&Cs for
20 patients experiencing miscarriage, correct?

21 A. Yes.

22 Q. Do you know how frequently your patients
23 develop intrauterine adhesions after you
24 perform a D&C?

25 A. No.

1 Q. When an embryo or a fetus has died in utero,
2 what are physician -- physician's options for
3 removing it?

4 A. So I'm going to rephrase it a little bit
5 differently. So if a patient comes to me --
6 and miscarriage is a very sad situation.
7 Many times women are devastated by the loss
8 of a child that they had already planned and
9 thought about and contemplated their birth.
10 When patients come to me with a miscarriage,
11 I typically offer them the opportunity of
12 expected management versus immediate
13 management with a D&C. Does that answer your
14 question?

15 Q. Yeah. I think I have a follow-up question,
16 though. What happens if there is fetal death
17 in the second trimester?

18 A. So with fetal death in the second trimester,
19 we are much more concerned with abort- --
20 with infection and hemorrhage. And so
21 typically, those patients in my experience in
22 every hospital in every program that I've
23 worked at are managed in the hospital.

24 Q. And --

25 A. They're not managed as outpatients.

1 Q. Have you managed those patients yourself?

2 A. Yes.

3 Q. What have you done to manage them?

4 A. Either -- before misoprostol we would have to
5 dilate the patient's cervix with laminaria
6 and then do essentially a D&E, dilation and
7 evacuation, but not a D&E in the sense that
8 it was not on a living -- it was on a demised
9 fetus. With misoprostol, management has
10 become much more straightforward.

11 Q. What is management like now that
12 misoprostol --

13 A. We give them --

14 Q. -- exists?

15 A. -- high doses of -- of -- I'm sorry. We give
16 them misoprostol orally. I -- some
17 clinicians may give it vaginally and that
18 usually effects expulsion. E -- that should
19 be e-f-f-e-c- -- thank you.

20 Q. So in Paragraph 94 of your declaration you
21 discuss a report produced by an organization
22 called Advancing New Standards in
23 Reproductive Health, correct?

24 A. Uh-huh. I'm sorry. Yes.

25 Q. And that report was an analysis of a report

1 produced by the FDA entitled, Mifepristone
2 U.S. Post-Marketing Adverse Events Summary
3 through 12/31/2018, right?

4 A. Yes.

5 Q. And you describe as demonstrably false the
6 report's assertion that it is mandatory to
7 report any death among someone who used
8 mifepristone, correct?

9 A. Yes.

10 Q. What is your view to arrive at your
11 conclusion that that statement was
12 demonstrably false?

13 A. I reviewed FDA's REMS for mifepristone and I
14 also reviewed their postmarketing protocols.
15 Their postmarketing protocols are very
16 specific in stating for the REMS that
17 prescribers must report complications to
18 Danco or -- actually, it's not just Danco
19 because there's a generic manufacturer. But
20 let's say for this -- just the manufacturer
21 of mifepristone, prescribers must report
22 those to the -- complications to the
23 manufacturer who then reports them to FDA.
24 But if prescribers are not notified of
25 complications and those complications occur

1 and are managed in an emergency room or
2 elsewhere, they are never reported. And so,
3 therefore, it is not true. There is no
4 mandate on practitioners, physicians,
5 emergency room docs, gynecologists to report
6 those complications to FDA. That does not
7 exist.

8 Q. Do you consider yourself an expert on the
9 Federal Food, Drug, and Cosmetic Act?

10 A. Only an expert insofar as it affects my
11 practice and needing to understand the ways
12 that FDA's mandates and rules affect my
13 practice.

14 Q. Do the REMS for mifepristone affect your
15 practice?

16 A. No -- no, because I do not perform abortion.
17 However, it is incumbent to understand, as in
18 this situation, that, as I said earlier,
19 there is no mandatory reporting on the part
20 of everyday pres- -- of -- there's mandatory
21 reporting on the part of prescribers but not
22 on the part of other physicians who may
23 manage those complications. Without having
24 that information, it is impossible to
25 accurately ascertain what the true

1 complication rate is from mifepristone
2 abortions -- mifepristone/misoprostol
3 abortions.

4 Q. So between Paragraphs 113 and 114 of your
5 declaration you include a table, correct?

6 A. Yes.

7 Q. And that table includes deaths that the FDA
8 was aware of after a patient took
9 mifepristone, correct?

10 A. Yes.

11 Q. Does that suggest that those deaths were
12 caused by mifepristone?

13 A. They were associated with mifepristone.

14 Q. And what is your basis for saying that they
15 were associated?

16 A. The statement there under the paragraph --
17 the second double dagger where it says, The
18 fatal cases are included regardless of causal
19 attribution. So if there is no cause, then
20 you're really talking about association, that
21 the woman took it -- mifepristone and then
22 had -- experienced these outcomes.

23 Q. But doesn't the paragraph go on to say that
24 some of these deaths involved causes that
25 could not possibly have been associated with

1 mifepristone?

2 A. I disagree with that statement because I
3 believe and I think that there's evidence,
4 which I have supplied in my declaration, that
5 women do engage in risk-taking behavior, do
6 engage in unhealthy behaviors which can lead
7 to them dying from drug intoxication,
8 suicide, and so on and so forth.

9 Q. Do you believe that there's an association
10 between medication abortion and being the
11 victim of a homicide?

12 A. I think that if a woman undergoes a
13 medication abortion and then engages in
14 risk-taking activities, in particular drug
15 use, and I documented associations between
16 abortion and drug use, that she could put
17 herself in a situation where she could be the
18 victim of homicide.

19 MR. BOYLE: We've been going for about
20 another hour so whenever it's convenient, I'd
21 like to take a break.

22 MR. MENDIAS: Sure. I've got a few
23 more questions in this -- on this topic but
24 then after that, maybe ten minutes from now.

25 A. Yes, because I could use the ladies' room.

1 Q. So did this report -- or -- I'm sorry. This
2 table here includes all the deaths the FDA
3 was aware of between September 28th, 2000,
4 and June 30th, 2021; is that correct?

5 A. As far as I know, yes.

6 MR. BOYLE: Object to form.

7 BY MR. MENDIAS:

8 Q. And that was a yes?

9 A. No. It was -- I said, as far as I know. I
10 can't say yes or no because I wasn't the FDA
11 and I didn't collect the data.

12 Q. Did the report indicate how many women had
13 taken mifepristone in that period of time?

14 A. There are two parts to this report and I
15 didn't include everything, but they -- there
16 is a -- somewhere in here there is a
17 denominator. Again, I think that it would be
18 very difficult to identify which -- whether
19 women took mifepristone or not because,
20 again, we are relying on data that were
21 reported to the manufacturer. And as I said
22 earlier, those data are necessarily com- --
23 incomplete because there is no mandated --
24 mandated reporting for nonprescribers.

25 Q. Do you believe that the denominator is

1 inaccurate that the FDA reported?

2 A. Can you define what you mean by the
3 denominator.

4 Q. The number of women who took mifepristone in
5 that time period.

6 A. I don't know. I haven't reviewed their raw
7 data so I can't say.

8 Q. Did you encounter a figure that the FDA
9 provided as the number of women who had taken
10 mifepristone in that time period?

11 A. I want to say it was in the millions and the
12 number 2.6 million comes to mind, but that is
13 recollection so I can't really say that
14 that's completely accurate.

15 Q. And last month you submitted a declaration in
16 a case in Kansas, correct?

17 A. Yes.

18 MR. MENDIAS: Could I mark this as the
19 next exhibit. Thank you.

20 (WUBBENHORST EXHIBIT L, Declaration of
21 Monique Chireau Wubbenhorst, M.D., M.P.H.,
22 Kansas Case, was marked for identification.)

23 MR. BOYLE: Thank you.

24 BY MR. MENDIAS:

25 Q. And so on Page 39 of that declaration --

1 A. Yes.

2 Q. -- you include a very similar chart, correct?

3 A. Yes.

4 Q. And it reports the same number of deaths and
5 ectopic pregnancies; is that right?

6 A. Yes.

7 Q. Just give me one second. And above the chart
8 there is text from the FDA report, right?

9 A. Yes.

10 Q. And do you see the number of women indicated
11 there who took mifepristone through the time
12 period covered in the chart?

13 A. Yes. I think I said earlier it was in the
14 millions.

15 Q. Great. And what -- how many specifically
16 millions is it?

17 A. They say approximately 5.6 million.

18 Q. Why didn't you include that figure in your
19 report for this case?

20 A. I was at the point where I needed to keep my
21 text as short as possible. It was certainly
22 not because I was trying to run away from
23 that figure. I'm well aware of that figure.
24 It's commonly cited in the literature so it
25 was simply a question of trying to shorten --

1 keep my testimony as brief and to the point
2 as possible.

3 Q. And how long is your declaration report --
4 or, I'm sorry, your declaration submitted in
5 this case? That would be Exhibit B.

6 A. 64 pages.

7 Q. Okay.

8 MR. MENDIAS: I'm willing to take a
9 break at this point.

10 THE VIDEOGRAPHER: Going off the
11 record. The time is 3:33.

12 (Whereupon, there was a recess in the
13 proceedings from 3:33 p.m. to 3:49 p.m.)

14 THE VIDEOGRAPHER: Back on the record.
15 The time is 3:49.

16 BY MR. MENDIAS:

17 Q. Dr. Wubbenhorst, do you believe that maternal
18 mortality surveillance relies exclusively on
19 death certificates?

20 A. No.

21 Q. And do you agree that the gold standard for
22 ascertaining maternal mortality is to collect
23 data and then have a state-level group of
24 obstetricians and epidemiologists review
25 every case? Correct?

1 A. I don't think that's the gold standard for
2 ascertaining mortality. I think that that is
3 more related to ascertaining causes of
4 mortality.

5 Q. Okay. And you -- we were discussing earlier
6 the testimony that you gave in Kentucky. You
7 remember that testimony, correct?

8 A. I do. I'm thinking you have a copy of it.

9 Q. I might have given it already, but let me
10 see.

11 A. I don't believe you've given it yet.

12 Q. Correct.

13 MR. MENDIAS: So I'll mark this. Thank
14 you.

15 (WUBBENHORST EXHIBIT M, Excerpt of
16 Hearing Testimony by Dr. Wubbenhorst, was
17 marked for identification.)

18 BY MR. MENDIAS:

19 Q. And this is a transcript of the direct and
20 cross-examination you underwent, I believe,
21 last summer in Kentucky.

22 Does that look like -- correct to you?

23 A. Yes.

24 Q. Okay. And on Page 197 -- so -- and the
25 pages, again, are in the upper right-hand

1 corner of each small page in the --

2 MR. BOYLE: So objection. Is there
3 anything to identify this with?

4 MR. MENDIAS: Yeah. Let me -- well,
5 the witness has said that it looks familiar
6 so I can look for the full copy in a moment
7 but --

8 A. Yeah. I haven't -- I haven't seen this so...

9 Q. So on Page 197 --

10 A. Yes.

11 Q. Okay. Pardon me one second. All right.
12 Actually, we'll set that aside for the -- a
13 moment. I apologize for that.

14 Are you aware that the CDC has obtained
15 data on abortion mortality from all 50
16 states?

17 A. I -- on abortion mortality. I haven't looked
18 lately but, yes.

19 Q. Do you know the sources that the CDC relies
20 on to identify abortion-related deaths?

21 A. They pull from a variety of sources and I
22 would need to look precisely at their actual
23 method section of their MMWR.

24 Q. Do you know off the top of your head some of
25 those sources even if we'll acknowledge that

1 it's not all of them?

2 A. They rely on reports from the states. They
3 rely on death certificate data. There --
4 there are a few sour- -- data sources that
5 they use.

6 Q. Do they rely on reports by private citizens?

7 A. I don't know.

8 Q. Do you know what happens after the CDC
9 obtains a -- a report of an abortion-related
10 death?

11 A. My understanding is that they will try to get
12 as much information as they can regarding
13 that death.

14 Q. And then what happens, if you know?

15 A. Then they compile their data and report them.

16 Q. Are you aware of any review of the reports
17 that the CDC undertakes?

18 A. Well, that's what I meant, trying to get as
19 much information as possible.

20 Q. Okay. So could you say a little bit more
21 about what you mean when you say they try to
22 get as much information as possible.

23 A. They will try to get information about things
24 like gestational age and so on and so forth.
25 Again, I don't have their protocol in front

1 of me so I don't want to try to recite it
2 from memory.

3 Q. And are you aware of who at the CDC
4 undertakes the review of these reports?

5 A. I do not know. I would have to look at their
6 report to see that, which should be very
7 straightforward and easy to do.

8 Q. Okay. So back to Ex- -- Exhibition -- or
9 Exhibit B, your declaration in this case.

10 A. Just give me a moment. Yes.

11 Q. So in Paragraph 39 of your declaration you
12 cite a study by Cates and Grimes, correct?

13 A. Yes.

14 Q. And that study is to support your assertions
15 about the mortality rate of the D&E abortion
16 procedure; is that right?

17 A. No.

18 Q. What is it for?

19 A. It's to show trends. I was not citing
20 because that study's obviously very old, but
21 I was trying to make the point about methods
22 of D&E -- methods of abortion in the second
23 trimester and trends in how abortion data
24 were collected and so on and so forth. I was
25 not making a comment about mortality per se

1 in that era compared to this era.

2 Q. What trend do you think the study
3 exemplifies?

4 A. I think that it shows that the -- again,
5 using contemporaneous -- their techniques
6 were similar to what we use now, but it
7 showed that their rate -- the increase in
8 mortality in their study was fairly
9 substantial between 13 to 15 weeks and
10 greater than 16 weeks. That was the point
11 that I was trying to make.

12 Q. So you acknowledge that the study is fairly
13 old and, as you say in your report, it looked
14 at D&E procedures performed from 1972 to
15 1978, correct?

16 A. That's correct.

17 Q. And that was before -- at least some of the
18 abortions in the study were performed before
19 the Supreme Court's decision in 1973 in Roe
20 v. Wade, correct?

21 A. That's correct.

22 Q. Do you know the circumstances under which an
23 abortion prior to Roe could be performed in
24 most states?

25 A. It depended on the state and it was -- it was

1 not as much of a patchwork as it was that the
2 legalization of abortion proceeded starting
3 with -- I believe was California and New
4 York. I don't know which one was first.

5 But, again, that's not the point I was
6 trying to make. The point I was trying to
7 make was the change in mortality rates that
8 occurred from 5.6 per hundred thousand at 13
9 to 15 weeks to 14 at greater than 16 weeks.
10 That's the point I was trying to make.

11 Q. Do you think that the rates -- the trend that
12 you're discussing might have been affected by
13 the medical procedures used 40 years ago?

14 A. I think that the D&E procedure they were
15 using then was similar to what we're using
16 now. And in the second part where I talked
17 about installation procedures and
18 prostaglandin and hysterotomy, the point I
19 was making there is that those procedures are
20 actually still used in some states and that
21 they're associated with significantly
22 increased rates of mortality.

23 Q. Do you believe that PPSAT uses any procedure
24 other than D&E for abortions in the second
25 trimester?

1 A. Not to the best of my knowledge, but, again,
2 that's not the point I was making. I was
3 looking at overall abortion-related
4 mortality.

5 Q. Do you believe that advances in medicine
6 could have undermined the conclusions of the
7 study with respect to the trend across
8 gestational ages?

9 A. I can't speak to that. I can't say what
10 could or could not have happened.

11 Q. Do you believe that medicine does advance
12 over time?

13 A. Yes.

14 Q. And are you aware that the study's authors
15 found that out of 234,000 D&E abortions,
16 there were only 18 deaths?

17 A. Yes, I'm aware of that. But, again, the
18 point I'm trying to make was not related to
19 mortality rate per se; it was related to
20 mortality rate as it increases with
21 gestational age.

22 Q. Are you aware that the authors of the study
23 concluded that D&Es performed in nonhospital
24 settings had lower death-to-case rates than
25 those performed in hospitals?

1 A. I'm aware of that, but, again, that's not the
2 point I was trying to make by citing this
3 study. And, again, the study is not
4 contemporaneous.

5 Q. And are you aware that the study's authors
6 concluded that comparative mortality data
7 indicate that performing D&E outside of
8 hospitals carries no greater risk of death?

9 A. Oh, yeah, I'm aware of that, but, again, as
10 you said, this study is how old now?

11 Q. Doctor, you've expressed doubts with the
12 completeness of the CDC's surveillance of
13 abortion-related mortality; is that correct?

14 A. Yes.

15 Q. Are you aware that this study relies on
16 annual abortion surveillance conducted by the
17 CDC at the time?

18 A. Am I aware of what?

19 Q. That the study relied on CDC's annual sur- --
20 abortion surveillance activities when
21 calculating mortality rate.

22 A. You're talking about the 1991 study?

23 Q. Yes.

24 A. Correct. I'm familiar with Willard Cates'
25 and David Grimes's work.

1 Q. Is it your view that abortion mortality
2 surveillance is more accurate in countries
3 like the United Kingdom with nationalized
4 health systems?

5 A. No, because I think they have the same
6 problem of ascertainment that we have here
7 and they also have significant problems with
8 issues around miscoding just as we have here.
9 And what I mean by that is that some abortion
10 deaths are coded as being due to pregnancy or
11 natural causes. And an excellent example of
12 that is the unfortunate young lady who I
13 mentioned earlier, Keisha Atkins, who died
14 as -- due to complications from a late -- I
15 believe it was between 38 -- 28- and 32-week
16 abortion who was listed as -- the cause of
17 death was pregnancy. So they suffer from the
18 same issues that we have in terms of
19 miscoding, in terms of inaccurate --
20 insufficient ascertainment.

21 Q. To be clear, Keisha Atkins died in the United
22 States, not the United Kingdom, right?

23 A. But I'm using that as an example of something
24 that I think is a phenomenon common to all
25 abortion statistics and not just abortion,

1 other causes of death as well.

2 Q. So why is the ascertainment better in Finland
3 than in the United Kingdom?

4 A. Because once you enter the health system when
5 you're born, you don't exit it till you die.
6 Every encounter with the medical system is
7 documented and every encounter with the
8 medical system, when researchers go to look
9 at it, they can look at what the coding was
10 and correlate it to a hospital chart if they
11 want to. We do not have those capa- --
12 capabilities.

13 Q. Sure. I asked you about the United Kingdom.
14 So do you have any basis to believe in the
15 United Kingdom the surveillance is different
16 than in Finland?

17 A. It is because the national health service is
18 a national health service, but it does not
19 enroll patients from birth to death and
20 collect comprehensive data on every encounter
21 with the medical system. They can collect
22 data administratively and then try to go back
23 and look at patient-level data, but to have
24 granular patient-level data requires
25 something like what they have in Scandinavia.

1 Q. Have you examined patient-level data or any
2 health service data from the United Kingdom?

3 A. Yes, I have looked at some -- some of their
4 data.

5 Q. In what context?

6 A. I was interested in some of their maternal
7 mortality data because what their data was
8 showing was that there were disparities in
9 maternal mortality between women of color and
10 white women even though they have a
11 nationalized health system. I have not
12 looked at patient charts because I haven't
13 gotten permission to do that.

14 Q. Do you believe that the data that you
15 reviewed was inaccurate?

16 A. It was aggregate data and I can't vouch for
17 its integrity or its quality.

18 Q. Do you -- are you aware that the authors of
19 the 1981 Cates and Grimes study found that
20 the death case rates for D&E in the United
21 States are consistent with British data?

22 A. I was not aware of that. And, again, the
23 point of my citing that study was simply to
24 show the difference -- the issues around
25 increasing mortality with increasing

1 gestational age. That was the point of my
2 citing it.

3 Q. And in Paragraph 179 of your declaration you
4 cite a source by Lanska. Can you say what
5 that source is.

6 MR. BOYLE: What paragraph is that,
7 please?

8 MR. MENDIAS: That was 179.

9 MR. BOYLE: Thank you.

10 A. Yes.

11 Q. What is that source?

12 A. It's a journal article.

13 Q. Okay.

14 MR. MENDIAS: I'm going to mark this,
15 please. Thank you so much.

16 (WUBBENHORST EXHIBIT N, Letters to the
17 Editor, 2/17/2017, was marked for
18 identification.)

19 MR. BOYLE: Thank you.

20 BY MR. MENDIAS:

21 Q. And, Doctor, this is not a journal article,
22 is it?

23 A. It's a letter to the editor. That's correct.
24 Yeah.

25 Q. So it was not peer reviewed?

1 A. Uh-huh. That's correct.

2 Q. And the letter was written in 1983, correct?

3 A. That's correct.

4 Q. And isn't it true that the only source cited
5 in this article -- or the only sources cited
6 in this article are from 1981 or earlier?

7 A. That's correct.

8 Q. And the --

9 A. The point -- I'm sorry.

10 Q. No. Go ahead.

11 A. If I can continue, the point I was making in
12 including these -- including this particular
13 letter is that it's stated in a very clear
14 and understand way that the -- I think it's
15 the first, second -- third paragraph on Page
16 362 where it says, The mortality rate for
17 vaginal deliver- -- excuse me. Excuse me.
18 The mortality rate for vaginal deliveries may
19 be artificially low because high-risk mothers
20 are more likely to have a cesarean delivery.
21 This effect could be eliminated by adjusting
22 for preexisting medical conditions between
23 the vaginal and cesarean delivery subgroups
24 as the authors did in calculating rates for
25 women who had an abortion.

1 So the only reason I was including this
2 was not as a way of comparing maternal
3 mortality, which was higher at that time.
4 And certainly, this is, you know, 40 year --
5 some-odd years ago, but it was easily -- an
6 easy-to-understand way of talking about how
7 high-risk moms are more likely to have a
8 cesarean delivery, which is associated with
9 increased risk for mortality than low-risk
10 moms.

11 Q. In defining a high-risk delivery, the
12 letter's authors assume that maternal
13 mortality following a cesarean is
14 approximately a hundred per 100,000; isn't
15 that correct?

16 A. Yes. But, again, I'm not looking at their --
17 or not citing their specific data. What I'm
18 trying to help to present and perhaps didn't
19 need -- and appreciate the opportunity to
20 make it clearer is that cesarean delivery is
21 associated with a higher mortality rate than
22 vaginal delivery --

23 Q. Do you believe --

24 A. -- and that when you combine maternal
25 mortality statistics, very often that

1 distinction is not made. That's the only
2 point I was trying to make.

3 Q. Do you believe that the mortality rate today
4 following C-section is a hundred per 100,000?

5 A. I just said a moment ago that I am not
6 relying on the maternal mortality statistics.
7 I am simply making the point that cesarean
8 delivery is associated with higher mortality
9 and morbidity than vaginal delivery.

10 Q. I understand. But I'm asking you if you
11 believe that the mortality rate today
12 following a cesarean section --

13 A. No, it's not.

14 Q. What do you think it is?

15 A. I think that the most recent statistics I saw
16 were that the -- I would have to look, but I
17 think the mortality rate for a cesarean
18 delivery is about ten times greater, but,
19 again, I would have to look to be sure of
20 that.

21 Q. And the authors of the letter conclude that,
22 Cesarean sections account for only 10 percent
23 of deliveries and 90 percent of maternal
24 mortality associated with childbirth; is that
25 right?

1 A. That was true then, but it's not true right
2 now --

3 Q. So you're not --

4 A. -- because we have a much higher -- sir?

5 Q. No. Go ahead.

6 A. No. Please complete your question.

7 Q. I just wanted to confirm. So you don't
8 believe that 90 percent of maternal deaths
9 associated with childbirth are attributable
10 to C-sections today?

11 A. No, I don't think that that's the case. I
12 think that the other point is that our
13 cesarean rate is much -- what I was going to
14 say is that the -- our cesarean rate is much
15 higher than it was at that point.

16 Q. Understood. Doctor, what is an ectopic
17 pregnancy?

18 A. It's an -- ectopic pregnancy, excuse me, is a
19 pregnancy that implants outside of the
20 uterus. It can implant in a variety of other
21 sites, but the majority of them implant in
22 the fallopian tube.

23 Q. And how common is ectopic pregnancy?

24 A. 1 to 2 percent of pregnancies in the United
25 States.

1 Q. What are the risks of an ectopic pregnancy?

2 A. Rupture with hemorrhage requiring urgent
3 surgical intervention; death; complications
4 of hypovolemia, for example, if she bleeds
5 and then suffers heart attack or other
6 complications as well.

7 Q. Do you know what the rate of each of those
8 risks is, how frequently they occur in an
9 ectopic pregnancy?

10 A. I couldn't tell you what -- the risks
11 associated with hypovolemia. I do -- I can
12 affirm that ectopic pregnancy is the leading
13 cause of first-trimester maternal death.

14 Q. Sure. Do you know the specific rate, how
15 many women per ectopic pregnancy die in this
16 country?

17 A. No. I think that the point is -- as I was
18 saying earlier, that it's fairly common,
19 happening in 1 to 2 percent, and it is not an
20 easy diagnosis to make always.

21 Q. Do you know at what point in pregnancy an
22 embryo can be visualized with a transvaginal
23 ultrasound?

24 A. Depends on the woman. So most pregnancies
25 and the radiology literature state that you

1 should be able to visualize an embryo
2 sometime between four and six weeks, but it
3 can be longer. Relates to tissue
4 characteristics, to the skill of the
5 operator.

6 Q. Would you consider a pregnancy of unknown
7 location to be equivalent to a confirmed
8 ectopic pregnancy?

9 A. No.

10 Q. And if a patient has a pregnancy of unknown
11 location but no symptoms of ectopic
12 pregnancy, do you consider that a suspected
13 ectopic pregnancy?

14 A. It's suspected until proven otherwise.
15 That's axiomatic in OB/GYN.

16 Q. So your opinion is that all pregnancies of
17 unknown location should be assumed to be
18 ectopic until ruled out?

19 A. Yes, because if you miss it and a woman dies,
20 then that's very bad.

21 Q. And so you said in your declaration that
22 ectopic pregnancy is a contraindication to
23 medication abortion.

24 A. That's correct.

25 Q. Why is it contraindicated?

1 A. I'm just quoting FDA's -- the prescribing
2 information there.

3 Q. Do you have your own basis for believing that
4 it's contraindicated?

5 A. I was just quoting the prescribing
6 information. I'm sorry. I'm just putting
7 this in order. Just my little thing here
8 of --

9 Q. Uh-huh.

10 A. -- keeping papers straight. Yeah.

11 Q. Okay. So you don't have any other knowledge
12 about why it might be contraindicated?

13 A. No, sir. I'm relying on what the prescribing
14 information states.

15 Q. Do you believe that mifepristone causes tubal
16 rupture?

17 MR. BOYLE: Object to form.

18 A. No.

19 Q. Do you believe that misoprostol can cause a
20 tubal rupture of an ectopic pregnancy?

21 A. Not to my knowledge.

22 Q. Would you agree that an ectopic screening
23 protocol that uses ultrasound and hCG testing
24 is appropriate?

25 A. Yes.

1 Q. Do you know PPSAT's protocol for providing
2 medication abortion when there is a pregnancy
3 of unknown location?

4 A. My understanding is that it relies on ruling
5 out ectopic pregnancy through -- or
6 attempting to rule out ectopic pregnancy
7 based on symptoms and history and not
8 ultrasound.

9 Q. Do you believe that PPSAT provides medication
10 abortion to patients without having first
11 performed an ultrasound?

12 A. Yes.

13 Q. Do you believe that PPSAT provides medication
14 abortion to patients without doing hCG
15 testing?

16 A. Can I just --

17 Q. Sure.

18 A. -- clarify that? So your question was do I
19 believe that PPSAT provides medication
20 abortion to patients without an ultrasound.
21 Yes. In -- in all cases, I don't know.

22 Q. So do you believe that PPSAT provides
23 medication abortion to patients without doing
24 hCG testing?

25 A. My understanding and the specific issue that

1 I was responsive to here was the pregnancy of
2 unknown location. Reading the -- what
3 Dr. Farris said, it appears that PPSAT does
4 not perform -- routinely perform transvaginal
5 ultrasound in a patient with pregnancy of
6 unknown location to rule out ectopic
7 pregnancy.

8 Q. If a patient seeking medication abortion
9 can't obtain one because she has a pregnancy
10 of unknown location, do you believe that the
11 law's requirement to document an intrauterine
12 pregnancy requires that patient to seek
13 further screening --

14 A. Can you --

15 Q. -- for ectopic pregnancy?

16 A. Can you --

17 MR. BOYLE: Object to form.

18 A. Yeah. Can you break that question down? I'm
19 sorry. It's --

20 Q. Sure.

21 A. -- long.

22 Q. So you understand that the law that you are
23 here testifying in support of requires the
24 documentation of an intrauterine pregnancy
25 before a medication abortion can be provided,

1 correct?

2 A. Yes.

3 MR. BOYLE: Object to form. You can
4 answer.

5 BY MR. MENDIAS:

6 Q. And if a patient because of that requirement
7 cannot obtain a medication abortion, is it
8 your understanding that anything in the law
9 requires her to seek further screening for
10 ectopic pregnancy?

11 MR. BOYLE: Object to form. You can
12 answer.

13 A. I'm really having trouble following you.
14 What -- what do you mean by cannot obtain an
15 abortion?

16 Q. Well, as you understand, the law does not
17 permit a medication abortion in cases of
18 pregnancy of unknown location, correct?

19 MR. BOYLE: Object to form. You can
20 answer.

21 A. That's correct. But if the patient has a
22 pregnancy of unknown location, it's -- you
23 must triage that patient to either a
24 diagnosis of ectopic pregnancy, intrauterine
25 pregnancy, or a failing pregnancy,

1 miscarriage. It doesn't mean that she can't
2 have an abortion. I don't understand what
3 you mean by that.

4 Q. If a patient prefers a medication abortion
5 but she doesn't have a documented
6 intrauterine pregnancy, do you believe that
7 she can get an abortion under the law?

8 A. If she has an ultrasound that diagnoses her
9 to have a living intrauterine pregnancy.
10 If -- if she has -- if -- she could either
11 have an ectopic pregnancy, in which
12 medication abortion would be entirely
13 inappropriate; she could have a miscarriage,
14 in which case medication abortion would be
15 inappropriate because she would have passed
16 that demised fetus on her own or potentially
17 needed follow-up down the road but certainly
18 wouldn't have necessarily needed to -- to be
19 treated for and charged for an abortion; or
20 she has a viable intrauterine pregnancy that
21 she could have an abortion.

22 So I'm -- I'm just not understanding
23 your question, maybe. Maybe I just don't --
24 I don't get what you're saying.

25 Q. You understand that some patients prefer

1 medication abortion over surgical abortion,
2 correct?

3 A. Yes. And those patients have the option to
4 get it when an -- a vi- -- an intrauterine
5 pregnancy is seen.

6 Q. And if they don't have a documented
7 intrauterine pregnancy --

8 A. Then they must be triaged to a diagnosis of
9 either intrauterine pregnancy, failing
10 pregnancy or miscarriage, or ectopic
11 pregnancy.

12 Q. And what does triaging mean?

13 A. You apply the appropriate diagnostic
14 procedures to make -- to identify the
15 location of the pregnancy.

16 Q. And if a patient refuses to comply with those
17 diagnostic procedures, what happens then?

18 A. Then you have an obligation to not administer
19 a medication that could -- that she either
20 doesn't need or would not be effective.

21 Q. Does anything in the law require that woman
22 to then seek ectopic screening elsewhere?

23 MR. BOYLE: Objection.

24 BY MR. MENDIAS:

25 Q. You can answer.

1 A. I don't understand the -- the legal issue. I
2 mean, I'm here as a witness on medical
3 issues; I can't speak to the legal issue.

4 Q. Okay. You've read the laws in question?

5 A. Yes, I have. But, again, I'm -- I'm here to
6 speak to the -- to the -- to the -- the
7 medical issues as an expert.

8 Q. Okay. So in Paragraph 268 of your
9 declaration...

10 A. Just give me one moment, sir.

11 Q. Sure.

12 A. Yes.

13 Q. So you say that if a patient's h- -- well,
14 you quote Dr. Farris who says that if a
15 patient's hCG levels are sufficiently high,
16 this may be evidence of ectopic pregnancy,
17 correct?

18 A. Yes.

19 Q. And you suggest that implicit in that
20 statement is that the patient must now
21 undergo surgical abortion in addition to
22 medical abortion; is that correct?

23 A. Okay. What I say is, Implicit in this
24 statement is the fact that because
25 appropriate diagnostic steps to rule out

1 ectopic pregnancy were not taken at the time
2 of the patient's initial visit, she must now
3 undergo surgical abortion in addition to
4 medical abortion.

5 Q. So --

6 A. So that's what I said and what I mean by that
7 is the fact that if the patient had had an
8 ultrasound that could confirm a diagnosis of
9 intrauterine pregnancy, ectopic pregnancy, or
10 miscarriage, she would have not received a
11 medication that she did not need and then she
12 would not have had to have both a medical
13 abortion and a surgical abortion.

14 Q. Is it your understanding that PPSAT only
15 offers the patient the option of a surgical
16 abortion in this circumstance?

17 A. That's not what I said here. What I said is
18 that the patient has already undergone a
19 medical abortion and now, because she did not
20 have an ultrasound to triage her to the
21 appropriate diagnostic category, she has to
22 have a surgical abortion in addition to her
23 medical abortion.

24 Q. Well, what is your basis for saying that she
25 has to have just now or in the report she

1 must now undergo a surgical abortion?

2 A. Because that's what their protocol says. It
3 says that if the hCG is elevated, they would
4 now do a surgical abortion. If there were --
5 was no -- if there were no chorionic villi or
6 gestational sac on that surgical abortion,
7 then she would have to go and be seen for an
8 ectopic preg- -- to diagnose an ectopic
9 pregnancy, whereas, if they had done the
10 transvaginal ultrasound initially and said,
11 okay, this is either -- we -- we don't --
12 this is either a -- we can't really tell what
13 this is, this could be a miscarriage, this
14 could be an ectopic pregnancy, it could be an
15 intrauterine pregnancy, and had tri- --
16 triaged her to the appropriate diagnostic
17 category, she would not have had to undergo
18 those procedures and pay for both of those.

19 Q. So my question is, if a patient returns after
20 a medication abortion with high hCG levels,
21 you believe the only option PPSAT says to her
22 is a surgical abortion?

23 A. No.

24 Q. What else do they offer her?

25 A. First of all, again, I'm not talking about --

1 I am talking about in the pre- -- patient
2 with a pregnancy of unknown origin where
3 you -- they did not do a screening ultrasound
4 to ascertain the location of the pregnancy.
5 If they then -- they did not do that
6 ultrasound, she comes back with high hCG
7 levels, they have no basis -- no diagnostic
8 basis for -- to have triaged her into one of
9 those three categories, then their own
10 protocol says that they perform a surgical
11 abortion.

12 Q. You believe that the protocol only includes a
13 surgical abortion at that point?

14 A. No. That's not what I'm saying. I'm saying
15 that is what their protocol says is part of
16 their algorithm.

17 Q. Do you believe a physician provides
18 substandard care if they do not provide every
19 medical service a patient might need?

20 A. I don't -- I think that that's a -- it's a
21 question that I really can't answer because
22 it's -- a patient's perception of need has
23 nothing to do necessarily -- or may not have
24 anything to do with actually what's medically
25 appropriate.

1 Q. When you treat patients, do you occasionally
2 refer them for services that you do not
3 provide?

4 A. Yes.

5 Q. Do you think that that's a shortcoming of
6 your medical practice?

7 A. Well, not so much in my current medical
8 practice, actually --

9 Q. It's something --

10 A. -- because I'm a hospitalist and my primary
11 responsibility is patients in labor.

12 Q. Do you believe that a physician who practices
13 in an outpatient setting and refers a patient
14 for medical services that physician does not
15 provide is deficient in some way?

16 A. Not necessarily. Depends on the clinical
17 situation.

18 Q. Are you aware of any early medication
19 abortion patients who have experienced
20 negative outcomes from an ectopic pregnancy
21 as a result of PPSAT's protocol?

22 A. No.

23 Q. In Paragraph 351 of your report --

24 A. Yes.

25 Q. -- you discuss a study by Barnhart, et al.,

1 correct?

2 A. Yes.

3 Q. And you say -- one moment. And -- okay.
4 Actually, Paragraph 354 you say in reference
5 to this study that, Performing a medical
6 abortion without identifying the location of
7 pregnancy goes against the recommendations in
8 this paper.

9 Where in Barnhart, et al., do they
10 discuss medication abortion?

11 A. They talk -- it's -- it's -- the point that
12 I'm trying to make there is not Barn- --
13 whether Barnhart discusses medication
14 abortion. The point -- the overarching and
15 much bigger point and the reason why there is
16 an enormous literature on pregnancy of
17 unknown location is that you must triage a
18 patient -- as it says in Paragraph 353,
19 Pat- -- patients must have an ultimate
20 diagnosis of an IUP, an ectopic pregnancy, or
21 spontaneous resolution of a pregnancy.

22 That is the point that I'm trying to
23 make. It's not whether they mention
24 medication abortion or not. It is simply one
25 of the best studies that synthesizes the

1 available consensus on pregnancy of unknown
2 location.

3 Q. So does the paper discuss medication abortion
4 at all?

5 A. It doesn't discuss it, but that's not why I
6 included it. The reason I included it here
7 is because it clearly states unequivocally
8 and as consensus that pregnancies of unknown
9 location must be appropriately diagnosed --
10 triaged into appropriate diagnostic
11 categories. That is the important point that
12 I'm trying to make here.

13 Q. I know you say that you are a hospitalist
14 now, but did you provide treatment to
15 patients in an outpatient setting?

16 A. Yes.

17 Q. Did you provide prenatal care to patients in
18 an outpatient setting?

19 A. Did I?

20 Q. Yes.

21 A. Yes.

22 Q. When you did provide prenatal care to
23 outpatients, at what point in pregnancy do
24 you typically begin seeing them for prenatal
25 care?

1 A. I started seeing them sometimes from very
2 soon after they had a positive home pregnancy
3 test.

4 Q. Can you estimate about how many weeks since
5 the patient's last menstrual period that
6 would have been?

7 A. So typically, for most women, they present
8 for care if they've done a home pregnancy
9 test early because they -- they -- when they
10 come in to see -- see us, it's typically
11 sometime between six and ten weeks I would
12 say.

13 Q. And when you provided prenatal care in an
14 outpatient setting, when would your patients
15 typically receive their first ultrasound?

16 A. As soon as they came in or maybe within a
17 week after they came in if they couldn't stay
18 for an ultrasound.

19 Q. And what sort of ultrasound was that?

20 A. Usually transvaginal -- abdominal and if, you
21 know, we couldn't see anything, then
22 transvaginal.

23 Q. And in Paragraph 358 of your declaration you
24 discuss -- well, apologies. You -- you first
25 cite the study in Paragraph 356 but are

1 discussing it there, a study by Borchert, et
2 al., correct?

3 A. Yes.

4 Q. And that is coauthored by Dr. Boraas, an
5 expert witness for plaintiffs in this case,
6 correct?

7 A. Yes.

8 Q. And you assert that, With a high
9 loss-to-follow-up rate, no conclusions can be
10 drawn related to risks for complications,
11 right?

12 A. Yes.

13 Q. Is there anything in the paper that you read
14 that suggests the patients who were lost to
15 follow-up were different in any meaningful
16 way from the ones who remained in the study?

17 A. You can't say. They -- they were lost to
18 follow-up so you can't say.

19 Q. Do you think that there was any information
20 taken about those patients initially?

21 A. I think that some information was taken, but
22 there's absolutely no way to determine from
23 the paper how the patients -- how the
24 distribution of risk factors or
25 sociodemographic factors or anything else

1 differed between the patients lost to
2 follow-up versus the ones that stayed.

3 Q. Dr. Wubbenhorst, you submitted a report to
4 the Inter-American Court of Human Rights,
5 correct?

6 A. Yes.

7 Q. And that was specifically an expert opinion
8 in support of the Republic of El Salvador in
9 a legal challenge to the application of its
10 abortion ban for a woman known as Beatriz,
11 correct?

12 A. Yes.

13 Q. Is it fair to say that you support
14 El Salvador's abortion laws?

15 A. Yes.

16 Q. Are you aware that abortion in El Salvador is
17 illegal in every circumstance?

18 A. Yes.

19 Q. Are you aware that it is punishable by up to
20 40 years in prison?

21 A. Yes.

22 Q. Are you aware that there are dozens of women
23 currently imprisoned in El Salvador?

24 A. I was not aware of that.

25 Q. Do you believe that pregnant women in North

1 Carolina who seek and obtain abortions should
2 be criminally prosecuted?

3 A. I think I said earlier in this deposition
4 that I do not believe that women should be
5 prosecuted. If I didn't say it then, then
6 I'm going to say it now. I think that we
7 need compassion for women. We need to help
8 them to see that there are alternatives to
9 abortion and help provide the -- that --
10 those alternatives, whether it's financial,
11 whether it's walking with them through
12 pregnancy. In talking with many, many women
13 who were looking at having abortions, the
14 number one thing they have said to me is, I
15 have no one to go with me through this
16 pregnancy. So I think that if we can provide
17 that, that's what we do. I do not agree in
18 prosecu- -- -cuting women or putting them in
19 jail just to be very clear.

20 Q. If you don't agree with that, then what
21 motivated your expert opinion -- or what
22 motivated you to submit an expert opinion in
23 support of a country that does such a thing?

24 A. I'm not a lawyer and I don't necessarily
25 agree with that, but the goal -- the stated

1 goal of the challenge to El Salvador's law
2 was to create abortion on demand at any
3 gestational age. The people challenging the
4 statute were very clear that that was what
5 they were trying to do. I do not agree with
6 that. How El Salvador deals with the
7 question of pregnant women who have abortions
8 is -- I don't nec- -- I do not agree with
9 that. I'll be very clear with that. But I
10 do not agree that their laws should be
11 overturned -- and not just El Salvador but
12 the rest of Latin America -- their laws
13 should be overturned to allow abortion on
14 demand at any gestational age.

15 Q. Do you believe that Beatriz was seeking
16 abortion on demand at any age?

17 A. I'm very familiar with the case. She was
18 not. She was seeking the -- looking for an
19 abortion because her child had anencephaly.
20 However, as I've just said, the people who
21 are seeking to overturn -- -turn the laws
22 have made it very clear in multiple arenas
23 that that was their goal.

24 Q. But Beatriz's family was a participant in
25 this litigation, correct?

1 A. The -- I don't know. I don't know.

2 Q. It's also true that Beatriz suffered from
3 lupus, correct?

4 A. That's correct.

5 Q. And isn't it true that women with lupus
6 occasionally suffers negative pregnancy
7 outcomes as a result of the lupus?

8 A. But I'm going to return to something I said
9 earlier. You cannot predict whether a given
10 woman -- all of our strategies around risk
11 are population-based risk stratification
12 strategies. They do -- cannot predict
13 whether a single patient will undergo a
14 complication. And in her case, she did not.

15 Q. And my question is whether a woman with
16 lupus -- at a population level, women with
17 lupus, if they face higher risks of
18 complications during their pregnancy as a
19 result of lupus.

20 A. They do. And if those complications occur,
21 then we intervene appropriately.

22 Q. And do those women also experience a higher
23 rate of death during pregnancy as a result of
24 lupus?

25 A. With good medical care, it is very unusual.

1 And as I've said, if a woman develops
2 complications like nephritis, encephalitis,
3 any other complication from lupus, we
4 intervene urgently and do what is best for
5 the mom.

6 Q. Do you believe that El Salvador is a place
7 that provides good medical care to women with
8 lupus who are pregnant?

9 A. From reviewing the -- her chart, which I did,
10 I reviewed her chart in its entirety, yes,
11 they provided excellent medical care.

12 Q. She had a C-section at 26 weeks, correct?

13 A. That's correct.

14 Q. Do you believe that is the standard of care
15 for a woman who seeks an abortion at 13 weeks
16 because of health concerns?

17 A. It has nothing to do --

18 MR. BOYLE: Objection to form. You can
19 answer.

20 A. It has nothing to do with abortion. It has
21 to do with the clinician's assessment of what
22 was the appropriate management for her at
23 that stage.

24 Q. If Beatriz decided that she didn't want to
25 bear the risk, whatever it might be, for any

1 individual woman with lupus --

2 A. Bear the risk of what?

3 Q. A negative complication or death from lupus
4 during pregnancy, the standard of care is to
5 deny her an abortion you feel?

6 MR. BOYLE: Objection to form. You can
7 answer.

8 A. I don't think we're talking about a standard
9 of care; we are talking about the law. The
10 law states that abortion is illegal. If she
11 had a complication and she needed to have
12 urgent delivery, that is not an abortion.
13 I've made that clear previously and I think
14 you understand that. That is not an
15 abortion. That is simply acting to preserve
16 the life of the mother, but the intent is not
17 to kill the -- the infant.

18 Q. But you did refer to good medical care that
19 met the standard of care that Beatriz
20 allegedly received, correct?

21 A. Because I reviewed the chart and I felt that
22 she did receive good medical care.

23 Q. And you say that that care helped her achieve
24 a goal of good medical care during pregnancy,
25 correct?

1 MR. BOYLE: Object to form.

2 A. I don't understand your question.

3 MR. MENDIAS: So I can -- I'll mark
4 this as an exhibit. Thank you.

5 (WUBBENHORST EXHIBIT O, Expert Opinion
6 Report, Dr. Monique Chireau Wubbenhorst,
7 Beatriz, was marked for identification.)

8 MR. BOYLE: Thank you.

9 MR. MENDIAS: Uh-huh.

10 A. Great. Thank you for providing this.

11 Q. Uh-huh. So on Page 38 of that report, the
12 first nonindented paragraph, the one that
13 begins, Like other women --

14 A. Yes.

15 Q. -- can you read the first two sentences --

16 A. Uh-huh.

17 Q. -- of that paragraph.

18 A. Like other women, Beatriz had the right to
19 enjoy a good state of health to the extent
20 possible given her lupus. Good medical care
21 that met the standard of care helped her
22 achieve that goal during her pregnancy.

23 Q. So you believe her goal was to have an
24 emergency C-section at 26 weeks?

25 A. I'm not understanding your question. If

1 she -- she -- that was not her goal, but that
2 was an outcome of her pregnancy based on the
3 clinicians that were caring for her. And in
4 my review of the chart, that was an
5 appropriate decision.

6 Q. Her goal was to have an abortion at 13 weeks,
7 wasn't it?

8 A. I can't -- I'm not speaking to that question
9 of what her goal was or what her goal was
10 not. The question here is good medical care
11 met the standard of care that helped her
12 achieve the goal of having a -- a good state
13 of health during pregnancy. That is the
14 question that I am opining -- I opined on in
15 here.

16 Q. Do you believe that the risks of a C-section
17 at 26 weeks of pregnancy are greater than the
18 risks of an abortion at 13 weeks of
19 pregnancy?

20 A. Again, I don't think that that is a relevant
21 concept here. She continued her pregnancy.
22 She needed an emergency cesarean section at
23 26 weeks for indications that were well
24 understood, that were -- reflected good
25 medical care. It was -- would have been

1 impossible to foresee that she was going to
2 need a cesarean section at 26 weeks and so,
3 therefore, you can't compare the outcome of
4 her having an emergency C-section with the
5 outcome of her having an abortion. She had
6 good care. She got, from my viewpoint --
7 again, reviewing the chart in detail, she had
8 good care and when it was necessary to
9 deliver the baby, this was the mode of
10 delivery that was chosen.

11 Q. Okay. But my question was whether the -- you
12 believe that the risk of complications is
13 higher from a 13-week abortion than a
14 C-section at 26 weeks.

15 A. No. I think the risk of complications is
16 higher for -- I think the com- -- risk of
17 complications is higher for an -- for a
18 cesarean section 26 weeks, but I don't think
19 that's relevant to the question here.

20 Q. But she sought an abortion at 13 weeks,
21 correct?

22 A. That's correct.

23 Q. And if she had been permitted to obtain an
24 abortion at 13 weeks, the risk for
25 complications for a 13-week abortion would

1 have been relevant to her, correct?

2 A. I don't think so because, again, she could
3 have had an abortion at 13 weeks and had
4 perforation, had infection, had hemorrhage.
5 She could have had any one of a number of
6 outcomes. As I've said, risk is population
7 stratified. You cannot say what could or
8 could not have happened. That's speculative.
9 I can't respond to that.

10 Q. The population of women having C-sections at
11 26 weeks undergo much higher risks of
12 complications than the population of women --

13 A. But we're not --

14 Q. -- obtaining abortions --

15 A. -- talking about --

16 MR. BOYLE: Object. Object to form.

17 BY MR. MENDIAS:

18 Q. -- at 13 weeks.

19 A. We're not talking about --

20 MR. BOYLE: Object to form.

21 THE WITNESS: Okay.

22 MR. BOYLE: You can answer.

23 THE WITNESS: Thank you.

24 A. We're not talking about population; we're
25 talking about her. You can't say that she

1 would have had no risk to an abortion at 13
2 weeks. You can't say that. And she didn't
3 have any complications from her cesarean
4 section at 26 weeks. She died in a car
5 accident a few years later.

6 Q. Do you believe that her death was
7 attributable to the fact that she wanted an
8 abortion?

9 A. No. She died in a car accident.

10 Q. In Paragraph 47 of your report you say that,
11 Black women have two to three times higher
12 mortality from abortion compared to white
13 women.

14 A. Give me -- give me a chance to get there.
15 Give me a chance to get there. Yes.

16 Q. Do you know if black women also have a higher
17 mortality from childbirth than white women?

18 A. Yes, they do.

19 Q. Why would the mortality rate be higher for
20 black women from both abortion and
21 childbirth?

22 A. Because I think there are underlying
23 comorbidities that are more common in
24 African-American women, in particular
25 diabetes and hypertension. I think the other

1 reason that it's difficult to make that
2 comparison is that if you look at maternal
3 mortality statistics, the morbidity and
4 mortality for African-American women tends to
5 cluster in older ages and typically, women
6 undergoing abortion -- late abortion may be
7 older as well, but that discrepancy is most
8 likely due to -- although it's -- you know,
9 there's -- this is a very active area of
10 research. -- that those differences are
11 probably due to the distribution of
12 underlying health factors and possibly to
13 access to care as well.

14 Q. And in Paragraph 19 of your declaration you
15 reference, the deliberate targeting and
16 destruction of 17 million African-American
17 lives through abortions since Roe; is that
18 right?

19 A. Yes.

20 Q. Who deliberately targeted African-American
21 women for abortion?

22 A. I think that if you look at the history of --
23 of abortion and specifically population
24 control, it is very clear that black women
25 and African-Americans in general were seen as

1 the other -- especially in eugenic terms.
2 That's going all the way back to Galton and
3 Darwin and those other folks. But as you
4 continue that thread through the 20th
5 century, Fredrick Osborn said that abortion
6 is turning out to -- and contraception
7 turning out to be great eugenic advances of
8 our time. Others have said that abortion
9 is -- I think it was Lawrence Lader said that
10 abortion is -- is -- is especially useful
11 given in minorities who are likely to rise up
12 in armed rebellion. So you have a consistent
13 thread of a worldview that says that
14 African-Americans are subhuman and,
15 therefore, that the -- that abortion can --
16 has the potential for being a eugenic tool of
17 injustice.

18 Now, I want to be very clear in saying
19 that I am not saying that individual abortion
20 providers have eugenic intent in performing
21 abortions. I want to be very clear in saying
22 that. What I am saying is that the outcomes
23 of policy, especially as -- and practice
24 especially as they are related to abortion
25 have led to eugenic outcomes, namely, that

1 most abortions occur in African-Americans
2 even though we constitute only 13 to 14
3 percent of the population, that the
4 African-American population principally
5 because of abortion is in decline and has
6 been since the 1990s in terms of the number
7 of births every year.

8 So that's the point that I'm trying to
9 make, not attributing intent to anyone
10 because I can't know someone's intent, but
11 the outcome remains the same.

12 Q. Is it possible to have deliberate targeting
13 without intent?

14 A. I think you can -- again, I'm looking at the
15 outcome.

16 Q. Do --

17 A. I understand -- I understand what you're
18 saying, but, again, if the result is that you
19 have this enormous racial disparity in
20 abortion, I can't ascertain intent, but the
21 eugenic outcome is -- remains the same.

22 Q. And you can't ascertain whether it's
23 deliberate, correct?

24 A. What's that?

25 Q. And you couldn't ascertain whether the

1 discrepancy is deliberate?

2 A. Then how else would you arrive at the -- at
3 the discrepancy if it's not deliberate on
4 some level and --

5 Q. So the --

6 A. -- and especially if policy, especially
7 population control policy, has been directed
8 in -- in -- along those lines --

9 Q. Since --

10 A. -- since --

11 Q. -- 1972 -- '73?

12 A. No. Since -- since before that. Since the
13 Nixon era and since the 1960s. This -- this
14 antedates 1973. This has been going on for a
15 while.

16 Q. Okay. So, Doctor, I'm curious specifically
17 who you say is deliberately targeting and
18 destroying 17 million African-American lives.

19 Can you identify who's doing that
20 deliberate targeting?

21 A. I think that -- again, I am looking at the
22 outcome and I am looking at the fact that,
23 whether we like it or not, that disparity
24 exists. Whether we like it or not, the ugly
25 fact is that we have had 17 million

1 African-American lives destroyed, that we are
2 looking at the decline in the number of
3 births to African-American woman -- women,
4 that for every three births to
5 African-American women that occur, there are
6 two abortions.

7 So whether an individual practitioner
8 makes a deliberate -- is deliberately
9 targeting African-Americans, I don't know.
10 That may be true; that may not be true. But
11 as a policy statement, the net out- -- the
12 net outcome is the same.

13 Q. Do you believe that African-Americans who
14 obtain abortions are complicit in eugenics?

15 MR. BOYLE: Objection.

16 BY MR. MENDIAS:

17 Q. You can answer.

18 A. I'm not -- I don't know what that statement
19 means. How can you be complicit in eugenics
20 because eugenics is a worldview? Eugenics
21 says that one group of people is human and
22 one group of people is not human and because
23 this group of people is not human, you can
24 subject them to anything, any kind of
25 mistreatment, any kind of suppression.

1 That's -- that's the essence of eugenics as
2 defined by Galton in his speech in 1901. He
3 was very clear, according to Darwinian
4 theories, that some people were the fit and
5 others were not the fit. And the slogan of
6 the -- one of the slogans of the American
7 Eugenics Board was less from the fit -- less
8 from the unfit, more from the fit. That's
9 one of the goals of eugenics.

10 Q. Changing topics a little bit, Doctor, what
11 is, in medicine, an off-label use?

12 A. It's when a medication has been approved for
13 one specific indication but physicians use it
14 for another indication.

15 Q. Have you ever prescribed medications for uses
16 that differ than what's on their FDA-approved
17 label?

18 A. Yes. This is something, actually, that --
19 for a number of different medications, using
20 nifedipine to control blood pressure in
21 pregnancy. There's -- there's a list of --
22 of those -- of those medications.

23 Q. Is off-label use common in obstetrics and
24 gynecology?

25 A. I can't speak to how it's common -- whether

1 it's common or uncommon. I know that it's
2 something that I do and that many of the
3 clicians -- clinicians that I know do as
4 well.

5 Q. In going back to something we talked about
6 much earlier today, you mentioned that you
7 had seen -- that you had treated patients who
8 were suffering from postabortion
9 complications outside the United States; is
10 that right?

11 A. Yes.

12 Q. Where did you treat those patients?

13 A. Kenya.

14 Q. Is abortion legal in Kenya?

15 A. No. Well, it's -- the current status is that
16 it's -- I believe it's legal with
17 restrictions. I would have to check on the
18 exact -- the laws changed recently.

19 Q. Was abortion legal in Kenya when you treated
20 these patients?

21 A. Yes --

22 Q. How --

23 A. -- for specific indications. And the
24 patients that I treated were actually not --
25 had not been aborted by, like, back alley

1 abortions or, you know, self-abortions. The
2 abortions were carried out by NGOs,
3 nongovernment organizations, who had set up
4 abortion clinics in those areas and then when
5 their patients -- when those patients had
6 complications, they would -- they would come
7 in and be seen.

8 Q. Did you ever report NGOs performing illegal
9 abortions in Kenya to anyone?

10 MR. BOYLE: Object to form. You can
11 answer.

12 THE WITNESS: What's that?

13 MR. BOYLE: Object to form. You can
14 answer.

15 A. Yeah, I don't know what the indication was
16 for the abortions.

17 Q. So another topic. We discussed earlier
18 forensic use of the products of conception
19 after an abortion to identify a rapist.

20 A. Yes.

21 Q. Do you remember that? Do you know what
22 protocol PPSAT follows for maintaining a
23 chain of custody when it provides an abortion
24 to someone who's been a victim of rape?

25 A. No.

1 Q. You believe that a major flaw in studies
2 demonstrating the safety of abortion is that
3 they don't include review of patient medical
4 charts, correct?

5 A. I wouldn't say it's a --

6 MR. BOYLE: Object to form.

7 THE WITNESS: Okay.

8 MR. BOYLE: You can answer.

9 THE WITNESS: Okay. Thank you.

10 A. No, sir. I wouldn't say that it's a major
11 flaw because sometimes I think you have to
12 work with the data that you have and
13 sometimes the data that you have is not
14 perfect.

15 MR. MENDIAS: Can I ask how long we've
16 been --

17 THE REPORTER: I have three hours.

18 MR. MENDIAS: Three hours. Do you want
19 to take a brief break?

20 THE WITNESS: Thank you, sir. That
21 would be great. Another bathroom break would
22 be great. Oops. Wait.

23 THE VIDEOGRAPHER: Going off the
24 record. The time is 4:46.

25 (Whereupon, there was a recess in the

1 proceedings from 4:46 p.m. to 5:04 p.m.)

2 THE VIDEOGRAPHER: Back on the record.
3 The time is 5:04.

4 MR. MENDIAS: So, Counsel, I'd just
5 like to request given that Dr. Wubbenhorst
6 stated that she has an updated CV if, Ellis,
7 you could provide that by the end of the
8 week.

9 THE WITNESS: No problem at all. Yeah.

10 MR. MENDIAS: Wonderful.

11 THE WITNESS: Uh-huh.

12 BY MR. MENDIAS:

13 Q. Okay. So, Doctor, you testified that
14 abortion patients with complications do not
15 frequently return to the clinic that provided
16 the abortion; is that correct?

17 A. That's correct.

18 Q. What's your basis for that statement?

19 A. I believe it's in my declaration that ACOG
20 noted that 50 percent or fewer of patients
21 returned to clinic following their abortion.

22 Q. Do you know what year that ACOG statement is
23 from?

24 A. I'd have to look in here.

25 Q. Do you know if that's examined data from

1 North Carolina?

2 A. I don't know if that was including Nor- --
3 data from North Carolina.

4 Q. And going back to our conversation about
5 intrauterine adhesions after a D&C, you
6 remember that, correct?

7 A. Yes.

8 Q. So I think I asked how frequently your
9 patients had developed intrauterine
10 adhesions, but I just wanted to clarify.

11 Have any of your parent -- patients that
12 you've provided a D&C to developed such
13 adhesions?

14 A. So I have cared for women who have developed
15 intrauterine adhesions following prior D&C.
16 I have not seen my -- any of my own patients
17 who I performed D&C on return with
18 intrauterine adhesions.

19 Q. Is it possible that they sought care for
20 intrauterine adhesions from other providers?

21 A. I think that's possibly it. I think it's
22 also that I've practiced in a lot of
23 geographic locales over, you know, the last
24 30 years so it's entirely possible that if
25 they developed them, they could have seen

1 another provider.

2 Q. And what does it mean if a patient has
3 developed an intrauterine adhesion in terms
4 of consequences for her health?

5 A. So with Asherman's syndrome, intrauterine --
6 intrauterine adhesions, they're associated
7 with infertility and dysfunctional uterine
8 bleeding.

9 Q. Do you characterize that as a serious
10 condition?

11 A. With -- in the case of dysfunctional uterine
12 bleeding and -- I -- and I -- there's another
13 entity with which they're associated and
14 that's abnormal placental adherence and
15 that's actually quite serious.

16 Q. How frequently do patients develop abnormal
17 placentation as a result of Asherman's
18 syndrome?

19 A. I think that I describe that in my statement
20 and I can take a look and see, but the real
21 question was not so much the frequency
22 because, again, it's hard to get at the
23 frequency. It's that when patients develop
24 intrauterine adhesions, they are at higher
25 risk for going on to have abnormal

1 placentation and -- leading to adhering
2 placenta, which is a real obstetrical
3 problem.

4 Q. When you provided prenatal care to patients,
5 did you tell them about ectopic pregnancy?

6 A. I am not following your argument.

7 Q. Well, it was a question. When you --

8 A. I mean, your question. I'm not following
9 your question. Sorry.

10 Q. When you provided prenatal care to your
11 patients -- you remember testifying that you
12 did that, correct?

13 A. Yes. Yes.

14 Q. Did you counsel them on symptoms of ectopic
15 pregnancy?

16 A. If they came in and they did not have a -- a
17 pregnancy that could be seen in the uterus on
18 ultrasound, definitely.

19 Q. And what did you say to them as part of that
20 counseling?

21 A. So if we did not see a pregnancy on -- then
22 we would warn them that they might have a --
23 a -- an ectopic pregnancy, describe what an
24 ectopic pregnancy was, what the risks were.
25 And then they would return within 48 hours so

1 that we could rescan them and recheck their
2 hCG.

3 Q. Did any patients not return?

4 A. I've never had a patient not return.

5 Q. What symptoms would you counsel them to look
6 for concerning a ruptured eptoc- -- ectopic
7 pregnancy?

8 A. Well, I think that it's important to make a
9 distinction here between symptoms of ectopic
10 pregnancy which are transient and fleeting --
11 and, in fact, I wrote a paper -- cowrote a
12 paper in the Journal of American Medical
13 Association some years back that looked at
14 the unreliability -- how reliable were
15 different symptoms.

16 So the diagnosis of a ruptured ectopic
17 pregnancy is fairly straightforward. Women
18 will often say they felt a pop, they
19 experienced terrible pain in their right
20 side, and they may feel faint. But one of
21 the problems that arises with that is that
22 they don't always associate that with -- they
23 think, oh, I have, you know, a ruptured cyst
24 or something like that. And so the real
25 danger is that they are not symptomatic

1 enough that they seek medical care and they
2 bleed and bleed. And healthy young women
3 have an amazing ability to adapt to loss of
4 blood, but once they run out of those
5 adaptive capabilities, they just die. So
6 this is why diagnosing ectopic pregnancy is
7 so treacherous. Yes, if they rupture, it's a
8 little bit more straightforward, but even
9 sometimes when they're rupturing, it's not
10 until they become faint or pass out or have
11 some other complication. And before that,
12 it's -- it's -- it's very protean. It can be
13 very difficult. They can -- they can have
14 bleeding that looks like a miscarriage and
15 they'll think that they've miscarried, for
16 example.

17 Q. At what point in pregnancy does ectopic
18 pregnancy typically present on an ultrasound?

19 A. So are you talking about at what point in
20 pregnancy is it typically diagnosed, sir? Is
21 that what you're saying?

22 Q. Sure.

23 A. Right. So usually, about the same time
24 plus -- you know, plus a few weeks as you see
25 an intrauterine preg- -- that you might

1 expect that you would see an intra- --
2 inter- -- intrauterine pregnancy you could
3 potentially see an ectopic pregnancy. Again,
4 the problem is that even with skilled hands,
5 it depends on -- very much on the hCG level
6 and there's some -- it depends on the hCG
7 level and there are sort of formulae or
8 algorithms that you use.

9 Q. So throughout your medical career as an
10 attending, did you train medical residents?

11 A. Yes.

12 Q. Has a medical resident ever lodged a
13 complaint about you?

14 A. No.

15 Q. Throughout your medical career have you ever
16 faced any disciplinary action --

17 A. No.

18 Q. -- from a hospital?

19 A. No.

20 Q. Have you ever received any disciplinary or
21 remedial action from a hospital?

22 A. No.

23 Q. Have you ever received any disciplinary
24 action from a state medical board?

25 A. No.

1 Q. You were with the faculty of Duke University
2 School of Medicine from 2003 to 2018?

3 A. Yes.

4 Q. It's correct that this is where you practiced
5 medicine for the significant majority of your
6 medical career, correct?

7 A. Yes.

8 Q. Under what circumstances did you leave Duke?

9 A. I was recruited starting in fall of 2017 to
10 the U.S. Agency for International
11 Development.

12 Q. How would you characterize your relationship
13 with Duke when you left?

14 A. I would say that it wasn't great. I think
15 that the -- it was hard to totally assess
16 this, but I had a sense that they were not --
17 you know, they were -- people were not in
18 favor of the pro-life work I was doing.

19 Q. What led you to that conclusion?

20 A. I think that people would say things to me.

21 Q. Such as?

22 A. You know, what -- what's the -- you know, why
23 are you doing this, you know, that type of
24 thing.

25 Q. So you weren't asked to resign from your

1 position at Duke?

2 A. No. No, I was not asked to resign.

3 MR. MENDIAS: Okay. I think that's all
4 the questions that I have.

5 MR. BOYLE: Give me just a moment, if
6 you would --

7 MR. MENDIAS: Sure.

8 MR. BOYLE: -- please. If -- if anyone
9 on the Zoom has any questions, I'll -- I'll
10 defer to y'all.

11 This is Ellis Boyle on behalf of the
12 legislative leader defendants. I don't have
13 any questions and I don't hear any from the
14 Zoom so unless -- I -- I guess that concludes
15 the deposition.

16 THE REPORTER: Sam?

17 MR. MENDIAS: Thank you very much,
18 Doctor.

19 THE WITNESS: Okay. Thank you.

20 THE VIDEOGRAPHER: Anybody on the Zoom?

21 MR. BOYLE: No. I think -- I think
22 we're -- we're clear. You can go off the
23 record. Thank you.

24 THE VIDEOGRAPHER: This concludes the
25 deposition. We're going off the record. The

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time is 5:15.

[SIGNATURE RESERVED]

[DEPOSITION CONCLUDED AT 5:15 P.M.]

A C K N O W L E D G E M E N T O F D E P O N E N T

I, MONIQUE WUBBENHORST, M.D., M.P.H.,
declare under the penalties of perjury under the
State of North Carolina that I have read the
foregoing 187 pages, which contain a correct
transcription of answers made by me to the question
therein recorded, with the exception(s) and/or
addition(s) reflected on the correction sheet
attached hereto, if any.

Signed this, the _____ day of
_____, 2023.

MONIQUE WUBBENHORST, M.D., M.P.H.

State of: _____

County of: _____

Subscribed and sworn to before me this
_____ day of _____, 2023.

Notary Public

My commission expires: _____

E R R A T A S H E E T

Case Name: Planned Parenthood South Atlantic, Et
Al. vs. Joshua Stein, Et Al.

Witness Name: Monique Wubbenhorst, M.D., M.P.H.

Deposition Date: Wednesday, August 30, 2023

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Signature

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Lisa A. Wheeler, RPR, CRR
Notary Public #19981350007

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